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ORIGINAL LECTURES.

MALPOSITIONS OF THE UTERUS.

A Clinical Lecture, delivered at the Long Island College Hospital.

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(Reported by Edward Develin, M.D.)

GENTLEMEN: You will remember that in my last two or three didactic lectures, I discussed, at some length, flexion of the uterus, giving you the nature and history of this deformity of the uterus, and also its pathology, as I understand it. I have here several cases of flexion and retroversion which will clinically illustrate some of the points which I endeavored to bring to your notice.

The first case is that of a young married woman, who has all of her menstrual life suffered from dysmenorrhœa, and has remained sterile since her marriage. The character of her dysmenorrhœa is precisely that which I described to you as occurring in flexion of the uterus. In making digital examination, I find that the os uteri points forward to an abnormal degree; in fact, it is directed almost towards the introitus of the vulva, whereas, as you know, it should point towards the sacrum. I also observe that the anterior portion of the cervix is almost on a line with the anterior vaginal wall; in fact, there is imperfect invagination of the cervix anteriorly, as if there had been arrest of development at this point; posteriorly, the invagination of the cervix is unusually great. Through the anterior vaginal wall I can detect the fundus of the uterus pointing towards the upper portion of the symphysis pubes. From this you will see that the cervix and body of the uterus are flexed forward; in passing the sound into the uterus, you will observe, by the sweep of the handle of the instrument externally, that it first passes backwards towards the upper portion of the sacrum, and then abruptly at the internal os, as I carry it along, it turns towards the symphysis pubes, thus proving, by the course of the sound, that the signs of anteflexion obtained by the touch are correct.

This case well illustrates two points to which I would call your attention—viz., that this form of flexion has associated with it almost invariably dysmenorrhœa, and also sterility.

CASE II.—Our next patient, also a married lady, before marriage suffered slightly from dysmenorrhœa. After her marriage, she became twice pregnant, and miscarried on each occasion. Since her first miscarriage, her dysmenorrhœa has been greater.

In making digital examination of this case I find the cervix in the normal position, but in pursuing my investigations backward behind the cervix I find a mass which feels like the fundus uteri, and which dips down in the cul-de-sac of Douglas almost as low as the termination of the cervix. These physical signs then indicate retroflexion, but in order to confirm this evidence I pass a sound into the cervical canal, which, you will observe by the handle of the instrument, passes in the normal direction until I reach the internal os. I then am compelled to turn the curved point of the sound backward, and it readily passes into the body of the uterus; the direction being downward and backward. In order to do this I am obliged to elevate the cervix upon the sound, so as to bring it more on a line with the body and fundus. Here we have, then, a case of well-marked retroflexion which, in all probability, existed to a slight extent before her marriage, but became aggravated during her few months of pregnancy, or was developed subsequent to her miscarriages.

You will remember that I told you, that in anteflexion sterility was most marked, and that in retroflexion there were some cases in which pregnancy occurred, but that in this deformity there was a liability to miscarry, unless the deformity was treated during gestation, so as to raise the fundus up into the normal position, and sustain it there while the development of the uterus is going on. Often when this is accomplished a complete cure will result. Much can be done during pregnancy in the way of treatment to prevent miscarriages. I will here illustrate the position of this deformity by a diagram upon the board, by which you will see that, while it is a deformity belonging to the same class as the previous case, it is just the opposite in the direction of the flexion: the one being forward and the other backward. We will now endeavor to restore this organ to its normal relationship by carrying the fundus upward and forward, and sustaining it there by means of a pessary. By comparing the two cases you will see at a glance in the first case, forward flexion of the body and cervix, and in this case retroflexion of the body alone, the cervix remaining in its normal position.

CASE III.—This patient is a lady in middle life; she has had five children and seven miscarriages. She comes to us because of these frequent miscarriages, and also because she suffers from a very distressing pelvic tenesmus, and an irregular and profuse menstruation.

In making my examination in this case, I find that the os uteri points towards the meatus urinarius, or, perhaps more correctly, the middle third of the urethra, the cervix being low down in the pelvis. I also find that the entire uterus is lying very low down in the pelvis; in fact, the fundus uteri is lower in the pelvis than the termination of the cervix, and between the cervix and the fundus there is a well-defined cul-de-sac. This shows that the body and cervix uteri are flexed upon each other; this is also, then, a case of retroflexion, but it is more than that, it is also a retroversion. Now you must understand that these two conditions may occur together. You will remember that in the second case there was simply a retroflexion, that is, the body was flexed backward, but the cervix was normal. Here in this case we find that the body is flexed upon the cervix, but at the same time the whole organ is lying further backward and downward in the pelvis than is normal, so that we have a combination of the two, a deformity and a displacement. This complication with flexion not infrequently occurs, and I may here call your attention to another complication of flexion which is not infrequently found, and that is anteflexion with a retroversion. I here represent upon the board an anteflexion of the uterus as it usually occurs. Now, suppose that I take that uterus, which is flexed forward, and carry the entire organ downward and backward into the position of retroversion? I would still have a deformity of the uterus, because the fundus is flexed

forward upon the cervix, but the entire organ itself lies further backward and downward in the pelvis than normal, so that we have an anteflexion with a retroversion. It is well to be able to make out these complications, and to know that they may occur, because, if we should fail to appreciate these conditions we might be somewhat puzzled to know just what the condition was.

To return to the case now under observation, we will endeavor first to bring the cervix and body of the uterus on a line with each other; this we will do by elevating the fundus, or rather changing it from retroflexion to retroversion, we will then maintain this condition of the uterus, if possible, by means of a pessary which will support the body. After a time, we will be able, by treating it as a retroversion, to elevate that fundus still further and maintain it in position; hoping, by so doing, that the atrophied walls of the uterus at the junction of the body and cervix may so improve in their nutrition and strength, that in time the uterus will be able to sustain itself in its normal relations.

If, after this, the patient should again become pregnant, we will watch her carefully, and sustain the uterus in position, until it is sufficiently developed to rise above the brim of the pelvis, and thereby be sustained, so that she may go on to her full term of gestation. If we can do this, and then watch her carefully after her confinement, and prevent the uterus from again becoming retroverted and retroflexed, we may succeed in curing her. But this is anticipating; for the present, it will suffice to try and relieve her present displacement and deformity.

CASE IV.—Our next patient is a married lady, forty-five years of age; she has been married eighteen years, and has one child. She complains of backache, leucorrhœa, and pelvic tenesmus.

Now, in this case, we desire to know what is the cause of this tenesmus, which is aggravated by walking, standing, or defecation, and also this backache, which, she states, is relieved on lying down.

I will first try to find out the cause by physical exploration. Now, in passing the finger along the vaginal walls, first I come in contact with the posterior wall of the cervix, which is just the opposite to what it should be: I find the os pointing towards the symphysis pubes. Passing my finger further back, I find what appears to be the fundus lying in the hollow of the sacrum, so that the axis of the uterus will correspond with the middle strait of the pelvis.

Now, if I were to attempt to pass the sound, I should find it would pass directly backwards. We find, then, that this is a case of retroversion. In replacing the organ, I pass a sponge into the vagina (using the sponge-holder), and make pressure upwards, at the same time introducing a sponge anterior to the cervix in a similar manner, and making equal pressure, the patient being in Sims' position. This is the most simple and the easiest way of restoring the uterus to its normal position in this form of displacement.

Now, in this case, I might very readily make a mistake; my *examination* here was not sufficient to prove the diagnosis. The mere fact of finding the cervix forward, and observing in the hollow of the sacrum a mass which generally indicates the fundus uteri, might be entirely a mistake. Suppose I find the cervix pointing towards the symphysis, and I find a tumor posteriorly, which represents the fundus of the uterus. Now, I might have an anteflexion with this mass posteriorly, and which to the touch feels like the fundus, but which may be simply a fibroid or ovarian tumor crowding the fundus forward.

This is a condition of things not infrequently found, and, on making a careless examination, it is pronounced to be a retroversion. In order to overcome the possibility of any source of error, it is necessary to pass the sound, when, if it is an ordinary retroversion, the sound will pass directly backwards.

I remember one of these cases where I came very near making a serious error. I was called in consultation, and was told by the physician in charge that he believed he had a case of retroversion. I made an examination, and, to the touch, it was a perfect case of retroversion. I tried to pass the sound, but the uterus was somewhat tender, and I desisted. I was about to abandon it, thinking the case was so plain, when I remembered that I would not have the opportunity of seeing the patient for some time; I therefore pursued my investigations a little further, and succeeded in passing the sound up to the fundus without any great difficulty, and by this means I could lift the uterus away up beyond the mass I had previously felt, and could get my finger between the body of the uterus and this mass, which proved to be a small ovarian cyst, which was extremely dense, and which felt equally as solid as the fundus itself.

This shows that, if we desire to be accurate in our diagnosis, we must not be satisfied with the touch alone, but must use the sound in these cases.

CASE V.—This patient is married, and is thirty-one years of age; has never been pregnant; she is troubled with dysmenorrhœa; further than this she is perfectly well. Now we must ascertain the cause of this sterility and dysmenorrhœa; the pain, she states, commences immediately at the beginning of the flow. This history is extremely brief, but so typical of this class of cases, and the physical signs coincide so well with the symptoms, that I will briefly put them together.

I will first represent upon the blackboard a section of the pelvis, including lines to represent the plane of the inlet and the outlet. I find the cervix pointing towards the introitus, and carrying the finger along the axis of the vagina, it comes directly in contact with the os externum, instead of the anterior wall of the cervix, as it should do. I find that this cervix occupies the position of complete retroversion. I pass my finger upwards in front of the cervix, and I find the fundus pointing towards the symphysis pubes, and the cervix looking in almost the same direction.

Now these physical signs, the forward flexion of the body of the uterus and cervix, coincide with the clinical history of sterility and dysmenorrhœa; they go together so generally that I need hardly discuss them separately. This patient has scanty menstruation. With the malformation of the uterus which we have here, the function of menstruation is very often irregular in quantity and duration, sometimes being scanty and at other times profuse. Early in the career of such cases it is often profuse, owing to the hyperæmic condition of the sexual organs; as they advance in life there is some change in the nutrition of the uterus which interferes with the development of the mucous membrane, and causes menstruation to become scanty, while in former years it was free. Now if we can straighten this uterus by throwing the cervix backward and raising the fundus, I have no doubt we will be enabled to relieve the symptoms which exist, but I have grave doubts as to relieving the sterility at this late date; the longer this abnormal condition exists the more doubtful ought we to be as to the possibility of overcoming the sterility. To overcome bad habits in these organs, it is desirable to take them in hand when young; the tendency at twenty years of age is to repair damages and defects of development, but at thirty it is not so to the same extent. So in this case we can hardly promise to relieve her of the sterility, but we can hope to relieve the dysmenorrhœa.

CASE VI.—This patient is suffering from menorrhagia, and has been since the birth of her last child.

I now propose to explore the cavity of the uterus to ascertain the cause of the bleeding. Upon passing this curette into the uterus I find that there is retroversion of the organ; I find it also to be beyond the normal size. On the withdrawal of the instrument I here find this piece of fungous growth which I removed from the anterior wall of the uterus; although, in my manipulations with the curette, I detached from the walls of the uterus a much larger amount than I here show you, and which I have brought away for inspection to complete my diagnosis. On passing the curette over the surface of the uterus, I could distinctly feel that I was separating a large quantity of this material. The posterior wall appeared to be quite smooth, but on the anterior wall I detected that scraping sensation which is caused by this fungous material. This patient had albuminuria during her pregnancy and perhaps made an imperfect recovery; there is also at the present time a marked catarrhal condition of the cervix and dilatation of the canal, conditions which frequently accompany these growths of the endometrium.

CASE VII.—The patient I here present to you is twenty years of age, she was married when eighteen, and comes to us suffering from menorrhagia which has troubled her many months. A week ago, during her menstruation, she states that she passed a large clot, since which time she has had a slight flow from the vagina. I will now make a physical exploration of the parts. You notice that as I pass in this probe it passes backwards, indicating a retroversion of the uterus, the physical signs of which I also obtained by the touch. On further examination I find it to be one of those cases of sterility resulting from displacement and corporeal endometritis, giving rise to those fungous or polypoid growths of the mucous membrane of the uterus; specimens of which I have often presented to you at my clinics. This is all sufficient to account for the sterility and menorrhagia.

The treatment is to remove the fungosities with the curette, and then restore the uterus to its normal position, and retain it there with a pessary. This may be all sufficient to relieve the endometritis, but, should that linger, the usual treatment for that affection should be employed.

ORIGINAL ARTICLES.

GALVANIZATION OF THE BRAIN, AND ITS VALUE IN THE TREATMENT OF CHOREA.[1]

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THE phenomena which result from passing a galvanic current through the healthy human brain, and through that of lower animals, are within certain limits quite well known. As regards the human brain, these effects may be classified under the heads of subjective phenomena, or those of which the patient is conscious, but which do not reveal themselves to the observer; and objective, or those which are apparent and can be noted.

The subjective phenomena, when galvanic currents of moderate or great intensity (5–40 Daniell's cells) are passed from brow to neck, are as follows:

(1) Pain, sensation of numbness and pressure.

(2) Malaise, faintness, nausea.

(3) Flashes of light, color-sensations, and dimness of vision. Auditory sensations (with powerful broken currents). Gustatory sensations (metallic taste, etc.).

(4) Dizziness, subjective and objective.

The flashes of light, metallic taste, and dizziness are most easily induced, and they are most prominent at making and breaking the current.

The objective phenomena are:

(1) Involuntary movements of eye (nystagmus, etc.).

(2) Movements of the head toward the anode on closure, toward the cathode on opening the circuits, with transverse currents. Disturbance of equilibrium.

(3) Convulsions (?). Very rare; not reported of late years.

(4) Unconsciousness. This I have produced in a girl aged eleven, by applying a current of Stöhrer's cells, with a very large anodal electrode covering both parietal bones. The condition was not that of syncope, as the face remained flushed, and heart-beat was strong and regular.

(5) Syncope—a psychical effect (?). Sleepiness.

(6) Salivation, vomiting.

(6) Lowering of temperature of surface (?).[1]

(7) Change in calibre of retinal vessels.[2]

(8) Change in the calibre of meningeal vessels.[3]

Besides the above there occur *After-effects:*

(1) Headache, head-pressure, dimness of vision, drowsiness.

In the diseased brain there follow, with more or less regularity, certain therapeutical results, such as:

Relief of brain exhaustion, melancholia, habitual headache, cerebral congestion, irritative diseases of central origin; changes in apoplectic conditions and in chronic, inflammatory, and degenerative diseases.

In the hypnotic state, when neuro-muscular excitability is increased, Charcot states that the movements of various voluntary muscles can be excited by acting upon the cranial surface over the motor centres.

In the lower animals, owing to the fact that stronger currents can be used, more marked objective symptoms can be brought out. These are:

(1) More pronounced movements of head, and of eyes; convulsions.

(2) Changes in the calibre of the meningeal (pia mater) arteries.

These vascular changes are as follows:

(*a*) With *ascending currents*, cathode to brow, anode to neck; in other words, with cathodal galvanization: dilatation of pial vessels, and increase in rapidity of flow of blood.

(*b*) With *descending currents* (anodal galvanization): generally a contraction of pial vessels, not always very marked.

(*c*) With *transverse currents:* dilatation of vessels on the side of the anode, contraction on the side of the cathode.

[1] Read at the meeting of the American Neurological Association, June 20, 1883.

[1] Letourneau, Journ. de Thér., viii. 9, p. 321, 1881.

[2] Ibid. Bull. de Thér., xcv. p. 130; Gazette Méd., 2 s., xv. 38, 1878.

[3] All of the foregoing effects that are produced by direct excitation of the brain can also be produced reflexly by stimulation of afferent nerves—a significant fact.

As a result of direct electrical irritation of the exposed brain of animals, we get certain phenomena not observable when the cranial bones are interposed. These are:

I. Contraction of voluntary muscles by direct irritation. This can be done better, and the motor regions more accurately mapped out, the higher in the scale the animal is, as regards neuro-muscular mechanisms.[1]

II. Excitations of special and general sensations.

III. Disturbances of equilibrium; forced movements.

IV. Changes in various neuro-mechanisms of organic life are also observable; *e. g.*, in the beat of heart, the tone of arteries, the rhythm of respiration, movements of stomach, intestines, bladder, Fallopian tubes, spleen.

Change in temperature.

Changes in the activity of glands; *e. g.*, the salivary, intestinal, and hepatic.

Below is given a table showing the results obtained by a number of experiments:

Experimenter.[2]	Animal Used.	Mode of Application.	Result.
Legros and *Onimus.*	Dog.	+ Pole to brow } = — " neck } (10 cells.)	Constriction.
		Reverse =	Dilatation.
Letourneau.	Dog.	— Brow + Neck } = ascending.	On breaking: Pupil widened; retinal vessels narrowed.
	Man.	— Facial nerve + Neck } = ascending. (10 cells.)	On breaking: Widening of pupil and narrowing of retinal vessels. On closure: Narrowing of retinal vessels.
		+ Facial nerve — Neck } = 18 cells (Onimus).	On closure: Contraction of arteries. On breaking: same.
Fisher. *Löwenfeld.* *Erb*, *Nothnagel.* *Riegel*, and *Jolly.*			*Faradic* and *galvanic* currents applied on cranium or thigh affect changes in cranial circulation; generally of congestion. Mechanical peripheral irritations do the same. Contractions of muscle-groups do the same.
Löwenfeld.[3]	Rabbits.	— Brow + Neck } = ascending or cathodal.	Arteries widen; circulation hastened.
		+ Brow — Neck } = descending or anodal.	Arteries narrowed, but less uniformly; circulation slowed.
		Transverse: + one side, — other =	Arteries widened on anode (+); narrowed on cathode (—). This difference persists.
		The vascular changes in ear and brain membranes do not run parallel.	

From the above, it will be seen how potent the electrical current is in modifying the functional activity of the brain.

A question of great interest now presents itself, and that is, In what way does the galvanic current produce the phenomena which result when percutaneously applied to the brain? A number of facts and theories have been advanced:

I. One thing which is, I believe, established beyond question is that these currents effect some changes in the tone and calibre of the meningeal bloodvessels. It is further quite definitely established[1] that the cathode or ascending current causes these vessels to dilate (in lower animals). It seems very probable also that the anode (or descending current), passed from brow to neck, causes a constriction of the bloodvessels. It yet remains to be shown, however, that this change is either constant or very marked. Transverse currents in lower animals have been shown by Löwenfeld[2] to cause dilatation of vessels on the side of the anode, and contraction on the side of the cathode, as has been stated.

It is well known that mechanical and electrical irritations of sensory, or pressor, and depressor nerves, in various parts of the body, will likewise cause, reflexly, changes in the calibre of the cerebral vessels. For example, cerebral congestion can be produced by irritating the sciatic. It has been thought, therefore, that the vascular changes above described are also the reflex of sensory irritations.

[1] The anode is more irritating than the cathode Asz > Ksz (Hitzig) when applied to the convolutions.

[2] For bibliographical references see Löwenfeld's "Electrotherapie des Gehirns." München, 1881. Erb's "Handbuch."

[3] Op. cit.

[1] Vide Löwenfeld, op. cit.

[2] Vide op. cit.

It is much more probable, in my opinion, judging from experiments with anæsthetized patients and narcotized animals, that these vascular changes are produced by a direct action of the current. The evidence, however, seems to me conclusive that these contractions and dilatations of the bloodvessels furnish only one factor in producing the various phenomena resulting from cerebral galvanization.

II. The theory advanced by Althaus, that these phenomena are mostly reflex from the action of the current upon the trigeminus, has been disproved.

III. The galvanic current, when passed through a nerve, changes its irritability, this being lowered at the anode (positive pole), raised at the cathode (negative pole), (phenomena of electrotonus).

It is possible that similar changes in irritability are produced by polar galvanization of the nerve-centres. Hitzig found, indeed, that the cortical motor centres responded more readily to the anode than to the cathode—the reverse of that which is the case with peripheral nerves. It has been suggested that this is due to the chemical action of the anode, which increases the acidity of the gray matter.[1] However this may be, Hitzig's observation does not prove that the general effect of the positive pole is not to lower and that of the negative to raise the irritability of the cerebral tissues as a whole. Experiment shows that the physiological effects of applying the anode are milder than those of the cathode; also that the anode very probably contracts the pial vessels, and slows the circulation. Clinical observation also shows, with hardly an exception, that the effect of the anode therapeutically is more agreeable and quieting.

IV. The galvanic current, besides its effect upon the bloodvessels and upon nerve-irritability, doubtless produces some direct change in the metabolism of the nerve-tissue, hastening, delaying, or modifying it. Whether these metabolic effects vary at all with the poles is uncertain.

V. The current acts to some extent upon the ampullary terminations of the eighth nerve, and probably thereby will cause dizziness and vertigo.

I have spoken of polar effects, and of ascending and descending currents. It appears to me that we ought to abandon the latter term as regards the brain, and perhaps also the cord. In passing a current from brow to neck, it descends some fibres and vessels, and ascends others.

I have found that by strictly polar electrization on the human brain the same phenomena result as by using the so-called current method; that is to say, the anode is, like the descending current, more mild. The well-known fact, that transverse currents produce unpleasant effects more easily than longitudinal, is readily explained by supposing it to be a polar action. The two sides of the brain have their irritability changed; the rapidity of nervous conduction is also changed, thence interference of nerve impulses and thereby disturbance of function. The blood-supply on the two sides is also, according to Löwenfeld, unequally affected.

[1] The gray matter of the cortex is neutral or acid; that of the white matter, alkaline. Acids go to the positive pole.

I believe we should gain by using the polar method and nomenclature in studying the effects of cerebral galvanization.

I am inclined to hope that I have devised a way by which more powerful effects can be gotten in the galvanization of the brain than by the ordinary methods. It consists in placing the foot upon a copper plate connected with the cathode, and placing the anode, a large curved sponge electrode seven inches by four, upon the head. It is known that with the peripheral nerves more powerful polar effects are gotten by having the poles far apart, and it appears to me that the same may be true as regards internal organs. Great caution should of course be used in applying these large currents, for even mild ones sometimes produce unpleasant after-effects.

I have said nothing about the question whether electricity really reaches and affects the brain, for that is settled by the investigations of Burckhardt, Rumpf, von Ziemssen, Erb, and others.

My conclusions regarding the percutaneous galvanization of the brain are:

1. That it is one of the most easily reached and easily affected of central organs.

2. That in ordinary galvanization the polar method and polar nomenclature should be used, since it is probably the pole and not the direction of the current which produces specific effects.

3. That the anodal galvanization of the brain probably lowers cerebral irritability, contracts the pial vessels, slows the circulation, and produces effects upon the nutrition of the brain.

4. That its action is chiefly a direct one, but is supplemented by reflex processes.

5. That possibly more powerful or special polar effects may be gotten by using widely separated electrodes.

We come now to the particular subject of cerebral galvanization in chorea minor. I believe ordinary chorea minor to be an irritative disease of some part of the gray matter of the voluntary motor tract. The irritation may be chiefly in the spinal cord, as seems to be the case sometimes in dogs; or it may be chiefly in the brain (*i. e.*, internal capsule, basal ganglia, or cortex), as is the case with the ordinary chorea of children and in the post-hemiplegic forms. The later developed or accessory portions of this motor tract are most affected; and these are parts most readily responding to electrical stimulation.

Chorea is not a disease which should be left to nature. It often, indeed generally, runs a cyclical course, but in the beginning the physician can never tell whether it will not cling to the child for months or years. Hence, the best therapeutical means should be promptly applied to its treatment. The reports as to the value of electricity in chorea have heretofore been most conflicting. The methods of applying electricity have also been varied and numerous. Benedikt, Remak, Onimus,[1] Beard and Rockwell,[2] Meyer,[3] Leube,[4] Jaccoud, von Ziemssen,[5] have

[1] "Guide Pratique d'Electro-thérapie," 1882, p. 193.
[2] "Medical and Surgical Electricity," p. 455.
[3] Meyer's "Medical Electricity," p. 350.
[4] Berlin. klinisch. Wochen., No. 35, 1874.
[5] "Cyclopædia of Practice of Medicine," vol. xiv. p. 468.

applied galvanism to the spine, Meyer, Leube, and Jaccoud using strong currents, the others weak currents. Von Ziemssen, and Beard and Rockwell do not speak well of it. The others claim good results. Althaus commends central galvanization with faradization of the affected muscles. Beard and Rockwell recommend general faradization in preference to galvanization in most cases.[1] Rosenbach and Steifert[2] apply galvanism to the tender points along the spine. Hammond speaks unfavorably of electricity in chorea, and Russell Reynolds[3] said in 1874 that electricity was of no use in this disease. The whole makes a somewhat unfavorable showing for electricity, and I should never have attempted its use, had it not seemed to me that it had so far generally been applied irrationally.

But, acting upon the hypothesis that anodal galvanization of the brain ought to prove sedative in functional spasmodic troubles of cerebral origin, I began some time ago to use this method in the treatment of chorea. It was not until recently, upon the appearance of the second volume of Erb's work,[4] that I learned that he and Berger[5] had been using anodal galvanization of the brain in chorea also. Neither of these authors, however, report detailed cases or give specific clinical facts upon which they base their conclusions. I, therefore, feel the more justified in presenting my results now.

I present here a record of eight cases, treated more or less systematically with galvanization of the brain.

CASE I.—Dora S., aged ten. Parents healthy; third in a family of eight, and the only one who has had chorea. Is the brightest scholar in the family and fond of study. Never had rheumatism; had a previous attack of chorea three years ago. First seen *Jan. 17th.* Present attack began about a week before. Is somewhat anæmic: has a mitral regurgitant murmur; it is loud, systolic, heard best at apex, is transferred and can be heard behind. Choreic movements chiefly on left side. Ordered liq. potass. arsenit., ♏ vj, t. i. d.

20th. — No improvement; worse if anything. Galvanism: anode to right parietal region; five Stöhrer's cells. Continued arsenic.

25th.—Was better for a day or two; then relapsed. Galvanism and arsenic.

Feb. 18.—Had improved for a time; then relapsed. Galvanism and arsenic. Did not return. Subsequently learned that she had rapidly recovered after last treatment.

CASE II.—Martha S., aged ten. Family history negative. Had had a previous attack one year ago. Never had had rheumatism. First seen *Jan. 8th.* Somewhat anæmic; no cardiac murmurs. Chorea began about a week ago; unilateral, left side. Ordered Fowler's solution, ♏ v, t. i. d.

15th.—Worse. Renewed arsenic, ♏ v. Applied galvanism, eight cells.

17th.—Better until to-day. Renewed above.

19th.—Same story. Renewed above.

22d.—Better. Applied galvanism only. Did not return.

CASE III.—Margaret H., aged eight. Family history negative. Has had no rheumatism and no previous attack.

Jan. 16.—First seen. Anæmic and poorly nourished. No cardiac murmurs. Attacks began six days ago, mostly on right side. Treated her with cod-liver oil, iron, quinine, and Fowler's solution—♏ vij–viij.

29th.—About same. Galvanism, six cells, five minutes. Fowler's solution continued in ♏ ix doses.

Feb. 2.—Had been very much better for two days, then gradually grew worse. Renewed galvanism and arsenic.

16th.—Better for a few days, then worse. Galvanism.

18th.—Better for a day. Galvanism.

23d.—Better to-day. Galvanism. Did not return.

CASE IV.—Lena S., aged fifteen. Family history negative. Had never had rheumatism; third attack of chorea.

Feb. 16.—First seen. No cardiac murmurs. Chorea very bad on left side; cannot use knife and fork; attacks began six or seven days ago. Applied galvanism, six cells.

18th.—Better; galvanism, three cells.

21st.—About same; improved for a day. Galvanism, three cells.

23d.—About same; gave Fowler's solution, ♏ vj, and galvanism, three cells.

28th.—About same; renewed above.

March 14.—Nearly well.

CASE V.—Alfred S., aged nine. History negative. Had no rheumatism or cardiac disease. Had a left-side ataxic chorea, not well marked. Would sometimes stumble and fall; could not eat well with left hand. Treated from April 11th to May 12th. Steadily improved under arsenic and galvanism, but chiefly the former.

CASE VI.—Sarah K., aged ten. Family healthy. Has had no rheumatism. Has had two previous attacks of chorea—one and two years ago respectively. Present attack came on two or three weeks ago. First seen *April 16th.* An active, healthy-looking girl. Has a mitral regurgitant murmur. Very severe chorea on right side. Cannot use the right hand to feed herself. Very restless and irritable. Ordered Fowler's solution, ♏ vj.

23d.—No improvement. Ordered Fowler's solution, ♏ vij, and galvanism.

27th.—Better; renewed above.

30th.—Better; renewed above.

May 2.—Better; renewed above.

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[1] Dr. Rockwell informs me that in his experience galvanization acts better in cases of chorea where the children are not very anæmic or ill-nourished. In this latter class he prefers to use general faradization.

I cannot consider that "central galvanization" as used by Dr. Rockwell is the same thing as the stabile anodal galvanization with large electrodes and gradually increased and decreased currents, described and used by myself.

[2] "Electro-therapie," Leipzig, 1882, R. H. Pierson, p. 184.

[3] "Clinical Uses of Electricity," p. 83.

[4] Handbuch der Elektrotherapie, Heft II., p. 568. Erb says "the recent chorea of children has been benefited very decidedly by electrical treatment, [anodal galvanization] and the disease materially shortened in many cases."

[5] Centralbl. f. Nervenheilkunde, No. 10, 1879, p. 220.

5th.—About same; renewed above.

9th.—Has been better, but is now worse, and is nearly as bad as ever. Has been taking arsenic.

9th–14th.—Gave daily galvanizations and continued arsenic. She steadily improved and is now practically well. The immediate improvement after the daily galvanizations began was notable.

CASE VII.—Irene B., aged fourteen. Family healthy. Had rheumatism last January. Had one previous attack of chorea. First seen *April 16th.* Patient not well developed. Has mitral regurgitant murmur and left supra-orbital neuralgia. Chorea began a week ago; it is very severe on the left side chiefly. She cannot feed herself with left hand. Ordered iron, quinine, and arsenic.

18th.—No better. Galvanism, two cells. Continued other remedies.

23d.—Much better; can feed herself. Renewed above, and gave cod-liver oil.

25th.—Better; no galvanism.

27th.—Worse, since galvanism was stopped. Renewed it with other remedies.

May 2.—Galvanism.

8th.—Has been kept on medicine alone and no galvanism. No improvement.

8th–14th.—Received galvanism every day and nothing else, except part of the time valerianate of zinc, which she had taken before without result. Is now practically well.

CASE VIII.—Bertha H., aged thirteen. Family healthy; is oldest of four children, and the only one affected with chorea. Never had rheumatism. First had chorea seven years ago when first sent to school; it was bilateral, but worse on left side. It has remained with her since, only disappearing mostly during fall and winter, reappearing in the spring. In spring of 1881 went to hospital, and remained there for one and one-third years. Could always feed herself and walk. Came out last fall well; continued so until about ten days ago, when arms and legs began to twitch, chiefly on left side; face not noticeably involved. First seen *May 7th.* General appearance good; is somewhat pale, quiet, well-grown. No cardiac murmur. Ordered Fowler's solution, ♏ viij, t. i. d.

9th.—No better. Fowler's solution, ♏ x.

16th.—If anything, is worse.

16th–23d.—Applied galvanism, 2–5 Stöhrer's, 6–8 Daniell's cells daily. No other treatment.

By *19th* was much better. On *23d* was well.

The first cases recorded showed me, as I believed, that galvanizations produced temporary improvement at least, when given only three times a week. The last cases convinced me that daily applications had a potent effect upon the disease.

The average duration of the disease in seven cases was thirty-four days; the eighth case, not a well-marked one, lasted about forty days. The average duration of treatment was twenty-five days. The average duration of the disease, according to See, is sixty-nine days; but this is too long for chorea as it occurs in New York. The average of about thirty cases, aside from the above, treated by me chiefly by arsenic was between six and eight weeks. It is not upon the statistics of duration, however, that I am led to believe in the efficacy of anodal electricity. I observed at first that patients would say that they felt better for the next twenty-four or thirty-six hours after the seance; then the old symptoms came back. This happened in such a number of instances that I could not believe it was coincidence. Again, some cases I treated with arsenic, with no result; I then added galvanism, and improvement at once began. In some instances, I used electricity alone, and with benefit. The electricity should be applied daily for at least ten days. If, after that, there is no improvement, it may be discontinued. When given only three times a week, it did not always effect good result. In those cases in which electricity was applied every day, I am inclined to think that arsenic or other specific medication is not needed.

What I claim for anodal galvanization is that it is a most valuable adjunct in the treatment of chorea; that given daily for a week or ten days with arsenic, and probably without, it will materially shorten the duration of the disease in most cases of chorea in children.[1]

The method of application is as follows: A large sponge-electrode of flexible brass, 4 by 2 inches, is thoroughly moistened with salt water. The hair of the patient is also thoroughly wetted, and the electrode applied over the side of the head, above the ear. In hemichorea it need only be applied over the side opposite to the one affected. The other electrode is placed in hand of the affected side. The electrode upon the scalp is made positive, and a stabile current of three to six Stöhrer's, four to eight Daniell's cells, is passed for from three to six minutes.

THREE CASES OF FOREIGN BODIES IN THE TRACHEA OR LARYNX; REMOVAL; RECOVERY.

Reported by H. R. WHARTON, M.D.,
SURGEON TO THE CHILDREN'S HOSPITAL; DEMONSTRATOR OF CLINICAL SURGERY IN THE UNIVERSITY OF PENNSYLVANIA, AND ASSISTANT SURGEON TO THE UNIVERSITY HOSPITAL.

CASE I.—Edward McC., aged seventeen months, was brought to the Children's Hospital on November 30, 1881, with the following history: A few hours before admission, while playing with some beans, he put one into his mouth, and apparently swallowed it, but was almost instantly attacked with a violent paroxysm of coughing and decided respiratory embarrassment. When the child was first seen, he presented the following symptoms: Marked dyspnœa, paroxysmal cough, great restlessness, and lividity of the face.

Prof. Ashhurst, who was in the hospital at the time of the child's admission, considered the symptoms sufficiently urgent to justify the performance

[1] Since writing the above, Nothnagel, in a clinical lecture on chorea, published in the *Allgemein wien. medicinische Zeitung*, recommends the use of galvanism by somewhat similar methods.

Dr. George W. Jacoby, of this city, informs me that three years ago, he and Dr. Rudisch used galvanization of the brain daily in a very considerable number of cases of chorea, but with unsatisfactory results. I cannot explain the difference between his experience and the contrary one of Rockwell, Erb, Berger, Nothnagel, and those just recorded above, except by assuming some difference in the technique of applying it.

of tracheotomy. Ether was administered, and the operation was accordingly performed, and the trachea exposed below the isthmus of the thyroid; a branch of the thyroid plexus of veins was divided, and bled profusely, but was easily secured and ligated. The trachea was then opened, and as soon as the edges of the tracheal wound were retracted, a forcible expiration occurred, which expelled the foreign body from the wound. This proved on examination to be a small white bean. The respiratory difficulty instantly disappeared, but as the trachea was quite flexible, and as its calibre might be interfered with by the pressure of inflammatory products, a small silver tracheotomy tube was introduced, and retained in position by the ordinary means.

The child reacted well, and presented no unfavorable symptoms; the tube was removed on the fourth day, and, at that time, the respiratory acts were carried on both through the wound and the mouth.

The further progress of the case was entirely satisfactory; with the exception of a slight attack of bronchitis, which rapidly responded to treatment, no unfavorable symptoms presented themselves, and the case was discharged from the hospital, with the wound healed, on December 14th.

CASE II.—James K., aged nineteen months, was admitted to the University Hospital May 3, 1883, with the following history: Four days before admission, the child, who lived in the country, some forty miles from Philadelphia, was amusing himself by biting grains of the common gourd seed corn from the cob, and feeding them to the chickens. While so employed, he accidentally inhaled a portion of a grain, and was instantly seized with a violent attack of coughing. As his symptoms became gradually worse on the fourth day after the accident, his physician advised his parents to bring him to the hospital. When admitted, the symptoms of dyspnœa were so urgent that Prof. Ashhurst was hastily summoned, and decided to perform tracheotomy at once. The child was given a few whiffs of ether; but as the respiration was much embarrassed, the incision was rapidly made and the trachea exposed without any considerable hemorrhage. The trachea was then opened, and the edges of the tracheal wound held open by wire retractors; respiratory movement had entirely ceased, and the child's appearance had become most alarming.

Artificial respiration was resorted to, and kept up for some minutes, even after all hope of resuscitation seemed to have passed; but finally a voluntary expiration occurred, which brought a portion of a grain of corn into the wound, from which it was removed.

Respiration was now thoroughly established, and was performed satisfactorily while the tracheal wound was kept open, but as soon as the retractors were removed dyspnœa again occurred. A small silver trocheotomy tube was now introduced and held in position in the ordinary way; it was thus found that the respiratory difficulty had subsided, and the breathing was carried on quietly by this means.

The child presented no unfavorable symptoms after the operation, but the attempt to remove the tube on the tenth day was unsuccessful, as the child soon presented symptoms of dyspnœa which necessitated the hasty reintroduction of the tube. Numerous attempts were made, even under ether, to remove the tube permanently; but all were unsuccessful for a like reason and the child was discharged from the hospital at the parents' request, wearing the tracheal tube, on June 26, 1883.

The case was again seen on July 23d, when it was found that the tube could be removed for a longer interval without alarming symptoms supervening. The parents were instructed to present the case from time to time, when attempts would be made to discard the use of the tube, but the case has not been seen since the last-named date.

The two preceding cases are of interest, especially, from the fact that the operation was performed upon quite young patients, both being under two years of age, and recovery following in both instances.

The condition noted in Case II., namely, the difficulty in the inspiratory act, the edges of the tracheal wound being drawn together and thus preventing the admission of air, apparently due to the extremely flexible condition of the trachea, is one that I have never before noticed.

Whether this was due to the normal flexibility of the trachea in a child of this age, or to the inflammatory condition of the mucous membrane at the seat of operation which had been set up by the prolonged presence of the foreign body, and had extended to the other elements of the trachea, causing a general inflammatory softening I am unable to decide, but that it was due to the latter cause in a measure, I am disposed to think, for in Case I., where the age of the patient was even less, the difficulty did not exist, and the tube was only introduced as a precautionary measure, as stated above.

The permanent removal of the tube after tracheotomy, as was seen in Case II., is sometimes a matter of great difficulty, but can generally be accomplished if sufficient patience be exercised, the tube being withdrawn from the trachea from time to time, and the child allowed to breathe without its use for a gradually increasing period of time at each withdrawal. That its permanent removal need not be despaired of is shown by numerous cases in which, even after the tubes had been worn from periods varying from several months to years, their use was finally dispensed with.

The difficulty produced by the removal of the tube is to be explained by the healing of the external wound, as far as the tube will permit, and its adhesion to the trachea, which causes it to assume a valvular action during the inspiratory acts; and also by the liability of the operation of tracheotomy to cause undue irritability and disorderly action of the muscles of the glottis, interrupting their usual rhythm; this latter fact has been pointed out by Mr. Thomas Smith.[1]

CASE III.—Ellen W., aged seven years, was brought to the Children's Hospital on Aug. 13, 1883,

[1] Medico-Chir. Soc. Trans., vol. xl. viii.

with the following history: On the previous night, while holding a pin in her mouth, she attempted to speak, when the pin suddenly disappeared, and she supposed she had swallowed it, until she was suddenly seized with a severe attack of coughing and pain, the latter she referred to the upper region of the larynx. When examined she presented no marked symptoms of dyspnœa, had a slight cough, and complained principally of pain and a sensation of sticking, which she located in the upper portion of the larynx. Upon digital examination, the point of a sharp body could be felt beneath the tissues a little to the right of the pomum Adami. As the child was very nervous and difficult to control, I decided to etherize her and endeavor to remove the foreign body through an external incision.

Ether was administered, and I made an incision a little to the right of the median line of the neck, and the tissues were divided, layer by layer, until the laryngeal fascia was exposed. At this step in the operation the point of the pin could be seen firmly imbedded in the right ala of the thyroid cartilage, and was seized with forceps and drawn out until its head impinged upon the inner wall of the larynx; the point was now bent to a right angle to prevent its falling back into the cavity of the larynx and thus being lost sight of. The wound was now enlarged downwards, so that in case of hemorrhage after removal of the foreign body the trachea could be rapidly opened and a tube introduced.

The pin was now seized with forceps, and a tenotomy knife introduced through the cartilage, close by its side, and the foreign body withdrawn without difficulty, a few bubbles of air only escaping, the edges of the puncture coming together, and preventing the further escape of air from the wound.

The external wound was closed with sutures, and a wet dressing applied.

The child reacted well from the ether, and was carefully watched for symptoms of hemorrhage into the larynx, but no unfavorable symptoms presented themselves.

The case progressed favorably until the third day, when an abscess formed in the wound, which was relieved by removing several of the sutures. After this, the child's recovery was rapid and uninterrupted, no laryngeal or tracheal symptoms presenting themselves; and the wound being entirely healed, she was discharged from the hospital on Sept. 6, 1883.

In the preceding case, the symptoms referable to the presence of the foreign body were not alarming, and I have no doubt that it could have been removed *per vias naturales*.

But as the child was extremely nervous and difficult to control, and as I feared that a delay might be followed by some change in the position of the foreign body, I decided upon the external operation, which seemed to offer the most speedy means of removing the offending body.

Mr. Semon[1] reported, before the Clinical Society of London, a case in which he removed a pin from the larynx of a boy, aged thirteen years, by the internal operation—that is, with the laryngeal forceps. In this case, the pin had been impacted for thirteen months, and the point projected a short distance into the œsophagus; there were fixation of the cricoarytenoid on one side, paroxysmal cough, and some difficulty at times in deglutition, but, on the whole, the symptoms referable to the presence of the foreign body were much less than would have been expected. A complete recovery followed its removal.

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[1] British Medical Journal, April 21, 1883.

MEDICAL PROGRESS.

THE COURSE OF THE FLEXOR LONGUS DIGITORUM PEDIS.—DR. SINCLAIR WHITE points out a mistake, occurring in some of the anatomical text-books on this point.

Having examined a considerable number of limbs with regard to this point, he finds that in no instance does the tendon of the flexor longus digitorum pass beneath the sustentaculum tali, its course being downwards and forwards over the inner surface of the astragalus and internal lateral ligament of the ankle-joint, in most cases grooving the upper part of the inner margin of the sustentaculum, and, in a few, passing above and in front of that process without touching it or any part of the os calcis in its course.

A glance at the articulated bones of the leg and foot will be quite sufficient to convince anyone of this. It will be seen that the groove on the back of the internal melleolus in no way corresponds with the concavity of the arch of the os calcis, and that the tendon passing down the groove on the back of the malleolus, could not gain the under surface of the arch, except by crossing over the prominent inner margin of the sustentaculum tali, and the tendon of the flexor longus pollicis, which lies immediately underneath that process; but the tendon of the flexor longus pollicis is not crossed by that of the flexor longus digitorum until the anterior margin of the os calcis is reached, so that the latter tendon must be internal to it behind that point. Inspection, however, of the recently dissected parts is the best proof.—*Journal of Anatomy and Physiology*, October, 1883.

DISLOCATION OF THE SEMILUNAR CARTILAGE OF THE KNEE.—Although this injury is described in all surgical text-books, we yet believe it is one that is not infrequently overlooked, especially on its first occcurrence. A gentleman falls down, and is picked up complaining of severe pain in the knee, with partial or complete immobility of the joint, which speedily becomes swollen. There is great likelihood that in these circumstances the diagnosis of "severe sprain" will be made, and the real condition remain unnoticed. The failure to replace the dislocated cartilage at the time not only entails much suffering and interference with the function of the joint, but it very greatly lessens the probability of a complete recovery ever being accomplished. The cartilage may be reduced, but it fails to become firmly fixed in its place, and ever afterwards there is a liability for it to slip out again during the free movements of the joint. When this happens, acute pain, possibly a fall as well, and temporary lameness are occasioned. There is, therefore, every reason why the surgeon should endeavor to recognize this particular injury on its first occurrence, and, having recognized it, to treat it properly. The accident hap-

pens during some sudden wrench to the joint, not necessarily severe; immediately severe sickening pain arises, and the limb is fixed in the flexed position, although passive movement is possible. Synovitis quickly ensues. If the cartilage is displaced from between the bones, or marginally, it forms a projection just over the interval, between the femur and tibia; but in some instances it is dislocated inwards, so as to lie between the two condyles of the femur, and then is quite beyond reach. In such cases the diagnosis must rest alone upon the cause of the accident—some wrench or sudden movement—the acute pain and fixity of the joint in the flexed position. The symptoms are more severe than those caused by a simple sprain of the joint from such an amount of violence, while on the other hand, the slipping of a loose cartilage between the bones causes still more acute suffering, and the body itself can be felt at times. The first thing to do is to replace the cartilage by extreme extension immediately following upon full flexion of the joint. In some cases the cartilage slips into place with a distinct snap, and in all cases the power of movement is at once restored. It is then important for the patient to wear a firm support to the knee for some months, which shall render impossible such a wrench of the joint as shall displace the cartilage, and if this is persevered in the cartilage again becomes adherent to the tibia. It is believed that the internal meniscus is more frequently displaced than the outer.—*The Lancet*, October 27, 1883.

RUPTURE OF AN ANEURISM INTO THE GALL-BLADDER.—CHIARI reports the case of a man, æt. 33 years, who, for a long time before his death, had suffered from attacks of cardiac pain. He died during a sudden and profuse intestinal hemorrhage. At the autopsy there was found in the transverse portion of the duodenum, in the upper surface, a round opening, two-fifths of an inch in diameter. This led into the gall-bladder, and further examination showed the ruptured sac of an aneurism of the cystic artery, which had burst into the gall-bladder. Besides this, there was also found, in the lower half of the gall-bladder, a second aneurism, involving the inferior cystic artery, and filled with thrombi. The stomach, intestines, and œsophagus were filled with coagulated and semifluid blood. This makes the fifth case on record in which the gall-bladder has been involved by an aneurism of the cystic artery. —*Centralbl. f. klin. Med.*, June 16, 1883.

RELATIONS OF THE DORSALIS PEDIS ARTERY TO THE CUNEIFORM BONES.—MR. AUTHOR HENSMAN states that the usual course of the dorsalis pedis artery may be indicated by a line drawn from the front of the ankle, midway between the malleoli, to the back of the first interosseous space.

This line will be found to cross in succession the fore part of the astragalus, the scaphoid, the middle, and also a small portion of the internal cuneiform bones.

In contemplating these facts it appeared to him strange that anatomists, in their descriptions of this artery, should have made no mention of the *middle* cuneiform bone, as one of its most constant posterior relations. In all the descriptions he had read with the view of ascertaining this point, he found that the internal cuneiform bone is always either named or clearly implied, but, as far as he had learned, the middle cuneiform is never even noticed.

It will be seen on dissection that this artery usually takes a fairly straight course between the points named; sometimes, however, it curves outwards, as if pulled aside by its tarsal and metatarsal branches, and in these instances its relations are necessarily somewhat altered. But he found when the direction of the artery is quite normal that it invariably crosses the broad base of the middle cuneiform, and merely touches (but not always) the fore and outer part of the internal cuneiform, just where it grasps the inner articular facet on the base of the second metatarsal bone. There is usually a slight scooping out of the pointed end of the cuneiform bone at this spot, and the artery most commonly occupies this little valley before dipping into the first interosseus space on its way to the sole of the foot.

After its passage over the middle cuneiform its deep relations are not constant. It may rest on the internal cuneiform as just stated, or, being more externally placed, it may skirt the inner side of the base of the second matatarsal, close alongside its junction with the inner cuneiform, or, finally, it may take a mid-course between the two, thus overlying both bones.

It can therefore, he thinks, be easily shown that this vessel always crosses the middle cuneiform bone, that it sometimes entirely avoids the internal cuneiform, and, moreover, that when it touches this latter bone it is for a distance short in comparison to the length of its path across the middle cuneiform bone.—*Journal of Anatomy and Physiology*, October, 1883.

THE STATE OF THE SENSITIVE NERVES IN STRYCHNINE POISONING.—In a recent memoir on this subject, PROFESSOR COUTY, of Rio de Janeiro, states that in his experiments strychnine intoxication does not cause an increased sensibility of the sensitive nerves, but a diminution of their excitability; a diminution which is increased in proportion as the action of the drug is prolonged. Prof. Couty's experiments were only made on the nerve-centres of the brain and spinal cord. The brain especially loses its excitability under the action of strychnine, while the experiments on the spinal cord, on the contrary, show that there is an exaggerated sensibility.—*Revue Scientifique*, Oct. 27, 1883.

A NEW PTOMAINE.—M. BRIEGER has discovered a ptomaine which forms during the digestion of albuminoid matters, and their transformation into peptone. The digestive act should not be prolonged, as in that case the ptomaine disappears. In order to obtain it, the digested matter is treated with ethylic alcohol; the insoluble parts are then treated with amylic alcohol (pure). This amylic extract is very toxic, and by successive purifications we may obtain a substance which, in doses of $\frac{1}{20}$ of a grain (in the impure state), suffices to kill a frog. To kill a rabbit, a dose of grs. vij–xv is sufficient. These animals, poisoned by it, die in a sort of a coma and stupor with paraplegia.

Other substances, such as fibrine, caseine, muscular tissue, and liver and brain tissue, also furnish this peptone. It is probable that it also forms during normal digestion, and if, as Mr. Brieger states, this is true, it is of great importance, especially in legal medicine.—*Revue Scientifique*, October 13, 1883.

TOTAL ABSENCE OF THE LEFT LOBE OF THE THYROID.—MR. WILLIAM J. GOW, Student, St. Bartholomew's Hospital, states that in dissecting a body lately, which was that of an old woman, apparently between sixty and seventy years old, it was found, on examining the front of the larynx, that the isthmus and left lobe of the thyroid gland were totally absent. The inferior and superior thyroid arteries on that side were exceedingly small, but each of them sent a slender branch to the place where the missing lobe should have been. The right lobe was not at all larger than usual, and showed no signs of ever having been united across the middle line, the borders being remarkably well defined. The remains of the thymus gland seemed larger than usual. —*Journal of Anatomy and Physiology*, October, 1883.

RISKS ATTENDING CATHETERISM IN CASES OF LONG-STANDING RETENTION OF URINE.—In commenting upon Sir Andrew Clark's remarks on catheter fever (see THE MEDICAL NEWS, November 10th, p. 512), SIR HENRY THOMPSON writes to *The Lancet* (October 27th) as follows:

The risk sometimes incurred by elderly men in commencing the use of the catheter, accurately appreciated by Sir A. Clark at the Clinical Society, and well described and commented on in your leading article, is a subject of great importance. It is, however, by no means unrecognized by surgeons, and has long been one of much interest to myself; so that I have made it a special topic for remark and caution in my clinical lectures.[1] I have so often observed the danger in certain cases associated with a resort to catheterism, although rendered absolutely necessary to relieve chronic retention of urine, that I have advised the greatest care and special management for them. But the dangerous and fatal results are rare as compared with the great number of elderly men who are compelled to depend for relief on the catheter, and who derive the greatest advantage and comfort from its daily use. For a case never becomes advanced and dangerous in regard of retained urine, unless the retention has been long overlooked or neglected, and when advice to empty the bladder in an early stage has unhappily not been given. If employed at that early stage, before the urinary organs have suffered damage from retention persisting perhaps through many months or even years, no fatal or dangerous "fever" will be met with. It is the *neglect of timely catheterism*, and not the employment of a catheter, which is the real occasion of the fatal issue, which now and then occurs under the circumstances described.

The first surgeon to point out the occurrence of this particular form of "fever" was Sir B. Brodie, in his lectures; and I beg you will allow me to cite an extract from my last edition, referring to his views, describing the symptoms, and indicating the method which I have adopted to diminish the risks which should mostly be expected, and always be provided for, when a pint or more of urine habitually remains in the bladder, despite the patient's efforts to relieve himself. The passage is as follows:

"I revert to a fact, already alluded to, which is one of considerable importance, that although the urine may have been quite clear before the catheter was employed, yet in some instances, after its habitual use has been continued for a short period, the secretion becomes cloudy, and the patient is feverish and unwell. A stage of constitutional derangement, more or less marked, has sometimes to be passed by those persons who, having long experienced difficulty, suddenly change from their usual mode of micturition to the artificial one. It requires some judgment, as I have already pointed out, to decide when this change should be made, but having made it, the phenomena described occur in a few exceptional instances; and this fact you should be aware of, and you should watch the result of the daily catheterism. Sir Benjamin Brodie was the first to remark it, and in his valuable lectures called attention to the circumstance that patients might even sometimes gradually succumb with symptoms of low or irritative fever a few weeks after beginning to use the catheter. Bearing this in mind, our mode of proceeding may be advantageously modified in relation to those patients whose amount of residual urine is large. It is then undesirable to empty the bladder completely on every occasion of catheterism during the first few days. If the patient has been in the habit of retaining perhaps a pint of urine, or even more, after he has made water, it is a serious change for the bladder to be suddenly and completely emptied two or three times a day; the organ soon becomes irritable, the urine is charged with pus, and the patient loses appetite, becomes feverish, and there is sometimes considerable danger to life. The rule under such circumstances is to proceed cautiously. Instead of removing the entire quantity, leave some urine behind; and thus a compromise is made between the exigencies arising in this condition of the bladder, and the usually absolute rule that it should be emptied. Draw off half or only two-thirds of a pint; you will thus relieve the organ partially, and in the course of a week or sooner you may gradually accomplish the entire emptying of the bladder, and all will probably go well. And it conduces greatly to success to permit no outdoor movement to such a patient, but confine him to his room, in a warm temperature, if the weather be cold, or even to his bed for a few days. The probationary period, while the use of the catheter has to be learned, and the onset of chronic cystitis with constitutional disturbance is to be feared, is more safely passed *if absolute rest and quiet* are accepted as necessary conditions by the patient. It is only within the last few years that I have pursued this course, and I cannot speak too highly of the results. Nevertheless, very rarely, notwithstanding every precaution, you will find a case in which during this process the tongue grows slowly more red, dry, and contracted; the powers of life gradually fail, the senses become impaired, and the patient sinks. You will always find in such cases, if an autopsy is made, old-standing pyelitis, with dilatation and marked degeneration of the renal structure, and you will know that in no circumstances could the patient have long survived" (p. 57).

The lesson to be learned—and it is an important one—is this. When the bladder of an elderly man fails to empty itself, let him learn to use a soft catheter without much delay: thus life with comfort may often be maintained to its natural term. Neglect the catheter until chronic disease of the organs is established, and a catastrophe may then be hastened by the use of the instrument. Scores of men whom I know in this town, between sixty and eighty years of age, still active, mature in mind, and more than ever serviceable to their fellows, owe their existence entirely to habitual catheterism.

THE FUTURE OF CEREBRAL SURGERY.—At the conclusion of his introductory address, delivered before the Royal Medical and Chirurgical Society, on October 23d, Dr. Ferrier made a most important observation, which cannot fail to prove of interest to all contemporary surgeons. He remarked that physicians would not be justified in advising surgical operations on the brain, and surgeons would refrain from active interference, until the principles and diagnosis of regional disease had been established with as near an approach to certainty as is possible, where all is hidden from the eye and hand. But, he continued, it is doubtful that any reason now remains why a surgeon, who fearlessly exposes the abdominal viscera, should not open the cranial cavity. Dr. Ferrier has seen complete recovery constantly follow some of the most formidable operations that have been performed on the brain and its coverings, in animals of the most delicate and almost human organization, when stringent antiseptic precautions had been taken. He cannot, therefore, but believe that similar results are capable of being achieved on man himself. Secondary inflammation can be absolutely prevented, and there is no risk to life from even extensive destruction of the cerebral

[1] Vide 7th edition, Lect. viii., chiefly devoted to the subject, especially the latter part, page 57.

hemispheres. In removing tumors or diseased cerebral tissue, no doubt healthy structures might be injured; but this would not necessarily cause mental disorder.

The triumphs of abdominal surgery, due in a great measure to advances in clinical and pathological science, and the correct appreciation of the physiology of abdominal structures and organs, have been followed by a great activity in the department of thoracic surgery. Surgeons now have the high authority of Dr. Ferrier to encourage them in untried efforts for the cure of cerebral disease by operation.

It may be said that trephining is a very old, and yet still a not very satisfactory practice; but hitherto it has generally been performed for the relief of some result of injury when deeper and more serious damage exists, or for the cure of a local condition implying, of necessity, more or less general disease of the brain. Tapping the pleura and Cæsarean section are also very old operations, practised long before thoracic and abdominal surgery had reached their present extended stage of dovelopment. They have been supplemented or superseded by operations performed with more deliberation, and not so often under conditions of emergency.

Through the labors of Dr. Ferrier, the future surgeon will probably perform with success operations which will bear the same relation to simple trephining as ovariotomy and Porro's operation bear to repeated tapping of ovarian cysts and Cæsarean section.—*British Medical Journal*, October 27, 1883.

INTESTINO-UTERINE FISTULÆ AND ARTIFICIAL ANUS.—DR. L. H. PETIT has recently written an elaborate article on this subject. The communications of the utero-vaginal canal with the small intestine, he says, are very rare. He has collected the records of twenty-three cases of ileo-vaginal and sixteen of intestino-uterine fistula.

Petit shows that of these cases, 14 followed strangulation of the intestine by rupture of the uterus or vagina; 18 cases followed pelvic phlegmon, which caused adhesions between the intestine and the vagina or uterus; in 2 cases an extra-uterine fœtal cyst opened at the same time into the intestine and uterus; in 4 cases uterine carcinoma had invaded the small intestine in the descending colon; and 1 case was doubtful, in that it could not be determined what point of the utero-vaginal or intestinal canal had been injured.

From an anatomical point of view these cases may be divided into simple fistula, and artificial anus properly so-called. The former follow adhesions of a loop of the intestine to the uterus or vaginal wall, from cancer or inflammation, only a limited opening being made in the intestinal wall; the latter are caused by strangulation of an intestinal loop in a rupture of the uterus or vagina, the whole circumference of the intestine being opened.

The symptoms of the two varieties are different. In cases of fistulæ there are intestinal irritation, escape of fecal matter through the vagina, but at the same time there are normal operations from the bowels. In the case of artificial anus there are symptoms of internal strangulation and the feces are passed through the vagina entirely. Differences are also seen in the progress, termination, prognosis, and treatment. Fistulæ gradully grow smaller, the feces pass in less and less quantities through the abnormal opening, and the case gets well, in the majority of cases, either of itself or after treatment consisting of vaginal and rectal injections, cauterizations and appropriate care of the patient. Artificial anus, on the contrary, does not tend to spontaneous cure, and it is only after the most persistent treatment, and operation that any cases get well.

As a rule, the diagnosis is easily made. It must be found out (1) whether the point of communication is in the uterine or vaginal wall; (2) if the rectum itself is implicated, or a higher portion of the intestinal canal; (3) if the lower portion of the intestine is permeable; (4) if the case is one of simple fistula or artificial anus; and (5) whether the lesion is of puerperal, cancerous, or what other origin. In making the examination, certain errors must be guarded against. Demarquay mistook the orifice of an artificial anus for the cervix uteri; and Radfort, an ileo-vaginal for a recto-vaginal fistula.

The prognosis is grave, in the sense that the affections causing the abnormal communications often cause death; but after the communications are once made, and the patient tided over the primary effects, the general state rapidly ameliorates, and the secondary effect, though very troublesome, is not incompatible with life. The treatment of these simple fistulæ consists in proper care, injections, tamponing the vagina, and cauterization of the opening. In vaginal fistulæ, the edges may be freshened and the opening closed by sutures. In the treatment of vaginal anus, the closure of the opening is only possible when there is no intestinal prolapse, and no spur (éperon), and when the lower portion of the canal is permeable. In cases of prolapsus, it is necessary to make a section and try to close the opening when the edges of the artificial anus have sufficiently approached a normal state to insure a passage of fecal matters after occlusion of the orifice. When there is a spur the enterotome must be used. When the lower portion of the bowel is obliterated, it is necessary to make a large communication between the upper extremity of the intestine and the rectal cavity. When these measures have been taken, the abnormal orifice may be sutured, after having been fastened. Occlusion of the vulva has been tried, without success. Gastrotomy has been proposed, in order to break up adhesions which may exist, and unite the two extremities of the intestine, but has not been tried.

When a vesico-vaginal and a fecal fistula exist at the same time, it seems to be advantageous to operate on both at the same time. Accidental communications of the small intestine with the uterus or vagina, of cancerous origin, tend to grow larger. They generally supervene at an advanced stage of the disease, and death soon carries off the patient.—*Ann. de Gynec.*, July, 1883.

TANNATE OF SODIUM IN CHRONIC NEPHRITIS.—Lewin first recommended tannate of sodium in nephritis, and Ribbert's experimental researches demonstrated its action in causing decreased elimination of albumen.

BRIESE has used it, in four cases in Mosler's clinic, prepared as follows: ℞. Solution of tannic acid, 2 parts to 100; add solution of bicarbonate of soda (9 to 5) ad react. alcalin. S. Dose, one tablespoonful every half hour.

This mixture was not equally well taken by the patients. In some cases it caused gastric disturbances and vomiting. The daily quantity of albumen eliminated by the urine was not diminished, the nephritis went on, and the patients grew worse daily, and it was apparent that the remedy was, in these cases at least, of no value whatever.—*Centralbl. f. klinisch. Med.*, September 1, 1883.

THE VALUE OF VACCINATION.—M. JULES FERRY has issued a circular, ordering the revaccination of all scholars in French public schools. This order is explained by the fact that it has been ascertained that, in those schools in which revaccination has been carried out, no case of smallpox has been known to occur for a series of years, the reverse being the case in many schools in which revaccination has not been carried out.—*British Med. Journal*, October 27, 1883.

THE MEDICAL NEWS.

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SATURDAY, NOVEMBER 17, 1883.

CICATRICIAL STRICTURE OF THE ŒSOPHAGUS: ITS CAUSATION AND MANAGEMENT.

IN the *Journal of the American Medical Association*, for October 27, 1883, Dr. H. F. Campbell calls attention to not less than twelve cases of cicatricial stricture of the œsophagus due to swallowing strong solutions of lye, as well as to eight additional instances of ingestion of the same caustic fluid, of which four proved promptly fatal from œdema of the glottis, in three no bad result followed, and in one serious injury ensued. As all of these cases occurred within a circle of twenty miles from Dr. Campbell's residence, Augusta, Georgia, it is obvious that accidents of this nature are far more common than one would have supposed; and its explanation is to be found in the fact that solutions of "concentrated lye," which appear to be largely used in washing, scouring, and other cleansing processes, are carelessly left in exposed situations, and are accidentally swallowed by infants and children, who constituted at least nineteen of the cases alluded to, their ages having varied from eighteen months to six years.

With a view to remedy the growing frequency of these accidents and the fatality resulting from them, Dr. Campbell urges that the sale of "Continental Concentrated Lye," and "The Star Ball Potash," which seem to be the most dangerous agents of their class, be interdicted by legislative enactment, or that the manufacturers be compelled to stamp upon the packages containing the articles the word "poison," and, for the unlettered, the recognized warning against danger—the death-head and cross-bones. In justice to the manufacturers, it should be stated that these articles are intended for making soap, and not as labor-saving expedients for lazy mothers and servants; but as they will doubtless continue to be diverted from their proper application, it might suggest itself to the dealers also to label their goods, in the event of legislative action on the subject, "Lazy mothers are warned that solutions of these substances should not be kept, lest they be drunk by children, and death ensue."

Turning to the primary object of the paper, namely, the nature and treatment of stricture of the œsophagus resulting from chemical injury, we are pleased to find that the author of the paper insists upon the frequent, if not invariable, coexistence of spasm of the muscular fibres of the gullet with the organic lesion, through which the latter may be rendered impermeable not only to food but to the passage of instruments. It is well known to surgeons that comparatively few cases of cicatricial stricture prevent fluid ingesta, and it is equally well known that the contact of solid food or of instruments in such cases is quite sufficient to close the constriction completely. These attacks of tonic spasm not only mislead the practitioner, but, if frequent and long continued, result in the death of the patient from inanition. It is under these circumstances that cutting operations are not uncommonly resorted to, and, improperly so, since, under ether, it will be found that, in the majority of instances, the spasm will yield to proper instruments carefully introduced, their effect being to progressively lessen the spasm with each insertion, at the same time that they induce absorption of the new material, especially if it be recently formed. Hence in these cases gradual dilatation should be instituted as early as possible, and be persevered in until the easy deglutition of solids renders the resort to bougies and probangs less frequent.

Cases are, however, met with, in which the patient is on the verge of starvation. The coarctation is impermeable to instruments, and is rapidly becoming, or has become, so even to fluid food. In such examples Dr. Campbell avers that no cutting operation should be practised for the object of nutrition until after the failure of rectal alimentation, which he considers a far more valuable measure for permanently supporting the patient than the experience of other surgeons would warrant. While in cases of complete or almost complete occlusion, we are disposed to endorse his views as to the impropriety of internal œsophagotomy and œsophagostomy, we are far from willing to admit that gastrostomy is not applicable to the class of cases under consideration. In not a few instances, indeed, it is a precious resource to prolong life. More than this, by placing the parts at rest, dilatation may

subsequently be resorted to with a prospect of success, when the gastric fistule may be closed. Had the operation been performed in some of the little patients that were permitted to die, a certain proportion would, in all probability, have been alive to-day. In a valuable article contributed to the AMERICAN JOURNAL OF THE MEDICAL SCIENCES, for April, 1883, Mr. Morell Mackenzie refers to twelve gastrostomies for cicatricial stricture, in which the trouble had existed, on an average, for five months before the operation, and in which life was prolonged, on an average, for five months and a half. Le Fort has shown in the *Gazette des Hôpitaux*, No. 90, 1883, that five patients were living, respectively, at the end of four months and a half, eight, twenty, twenty-four, and thirty-six months, and that five died, respectively, at the end of seven, seven, eight, fifteen, and eighteen months after the establishment of the fistule, results which surely indicate that the operation is perfectly justifiable.

The final histories of eleven of the cases quoted by Dr. Campbell, of which, however, only four occurred in his own practice, show that five that had no treatment died, on an average, in a little more than six months, and that of the six that were subjected to gradual dilatation, and in which the measure was begun early, the longest period after ingesting the lye having been three months, four were more or less complete successes, one died at the expiration of eighteen months, the treatment not having been systematic, and one was living, mainly on fluids, at the end of sixteen months. All of the patients, except a woman, thirty-four years of age, were young children, a class of subjects difficult to manage on account of the fear of pain and the disinclination of parents to distress the child if anything whatever can be swallowed, to which may be added, in not a few instances, the timidity evinced by the average general practitioner in passing instruments.

MODEL ABATTOIRS.

WITHIN recent years there has been a much-needed improvement in the manner of slaughtering cattle, in the construction and management of slaughter-houses, and in the methods of final disposal of the waste products of the business. This progress, however, has been chiefly identified with the abattoir system, private establishments for the most part still adhering to the old and defective methods. The difficulties in the way of regulating the construction and management of private establishments, so as to make them fully conform to a proper standard, and the obstacles encountered in instituting and maintaining systematic and scientific inspections, have been so great that reforms in this direction have made little or no progress.

In the light of this experience, efforts have been made to discourage the continuance of private establishments, and in their place to substitute the public abattoir system, which recommends itself as the only plan that has thus far met all sanitary requirements with respect to the lairage of animals, construction of buildings, management of the business, utilization of refuse, and which makes a daily inspection of all the details practicable. It is only by the adoption of this system, organized and regulated under the strictest sanitary supervision, that the public can feel confident that their interests are properly protected.

A very important movement in behalf of slaughter-house reform has been inaugurated in London under the name of the London Model Abattoirs Society. The objects of the Society, as stated at a recent meeting by the President, Dr. B. Ward Richardson, F.R.S., are the following: To establish in London a model slaughter-house, from designs of which others might be constructed; to advocate the erection of public abattoirs; to illustrate and teach the most rapid, skilled, and humane methods of slaughtering animals; to improve the method for the dressing of carcasses of animals, so that the flesh might enter the market in the purest condition; to insist on the importance of those engaged in slaughter-houses having proper conveniences for washing and cleansing themselves; to bring into use the completest means of removing offal, blood, and other organic substances, so that they might be moved with expedition; and to institute a systematic and scientific inspection.

Dr. Richardson is right in insisting on the necessity of replacing the private by the public slaughter-house or abattoir, on grounds of humanity, cleanliness, health, and economy. No better means could be selected for encouraging and giving force to this new movement than that adopted by the Society. Every one who is familiar with the present system is fully convinced of the grave character of its deficiencies. The lairage of animals is likely to be unsuitable and filthy; the slaughter-houses defective in construction and appointment, and therefore slovenly and dirty; blood-pits and storage receptacles neglected and foul; the slaughterers themselves unclean, and so likewise the storage department for the meat. The animals are made to suffer unnecessarily while waiting to be killed, are often cruelly and unsatisfactorily slaughtered, and the carcasses dressed and stored in an unwholesome manner. Without constant inspection, which is not possible under existing circumstances, these improper practices continue, and the meat is placed upon the market without ascertaining whether it is healthy or diseased. The facilities for removing the refuse matter are equally unsatisfactory, and for

this reason, this material is not disposed of with sufficient promptness to avoid a nuisance upon the premises.

To get rid of these evils, which so generally prevail in all cities, the abattoir system must be endorsed, encouraged, and legislated upon if necessary. A number of our cities have already established public abattoirs, notwithstanding the opposition by parties interested in the survival of the old plan. The experiment has been most satisfactory, and deserves to be extended. A movement such as that inaugurated by the London Society would do much towards cultivating a better appreciation of the subject, and in hastening the general adoption of a system which has so much to commend it.

JAMES MARION SIMS, M.D.

THE death of Dr. J. Marion Sims carries profound grief to the American profession. Not only in this country, but abroad, in whatever land true medicine lives, his departure will be mourned, for his fame and the influence of his teaching were almost world-wide. Sitting in the darkness of this sudden and great sorrow, it is natural to consider the work that he did in his busy life.

As there are epochs in the history of medicine with which famous names are associated, so there are famous names belonging to the special departments of medicine, names of those who have founded or greatly advanced those special departments. As the circulation of the blood suggests the name of Harvey, or pathological anatomy that of Morgagni, or obstetric anæsthesia that of Simpson, as vaccination always brings up the name of Jenner, or auscultation that of Laennec, so does gynecology—a department of medicine recent in origin—suggest that of Marion Sims; patient, brave, of restless activity; triumphant, noble man. He was a bold pioneer, opening new pathways; original, and with creative genius, he discovered for himself, and made his discoveries a gift to the profession. Even when unconsciously repeating what had been done before him, he greatly enriched the discovery, and carried the advance far beyond any predecessor. No matter what may be the great glory of those who have followed his footsteps, the best of them feel that they would never have accomplished what they have, had he not shown the way.

It is needless to say that before he faithfully worked out a method, the curing of genito-urinary fistulæ in the female was a rare exception, and now, thanks to his patient, self-denying labors, it is the rule. The best method of making uterine examinations he discovered and taught. He has done more than any man of his generation to teach not only the diagnosis, but also the most important surgical therapeutics of uterine diseases. Going to New York after many a hard lesson, after working out many a difficult problem unaided in his Southern home, and thus made strong in self-reliance, he gave an impetus to the study of diseases of women which must be felt long after his body mingles with kindred earth. The Woman's Hospital of New York, which owes its foundation to him, has been a school of the most valuable instruction to the profession; and that hospital has led to the establishment of similar institutions in various parts of the country, blessing those who are relieved in them, and blessing the profession, to whom they have been great centres of light. His treatise upon *Uterine Surgery* is one of the master-pieces of medical literature of the century. It has been translated into several foreign languages, and is found wherever there are educated physicians.

It would require much space to give even a list of the instruments Dr. Sims has invented for the diagnosis or treatment of uterine diseases. Many of these are found in the consulting rooms of all gynecologists, and in all hospitals where diseases of women are treated. If to-day all the publications of his pen and all the instruments of his device were destroyed, a great blank in gynecological science and art would be made, a blank that would remain for years.

He was a man constantly trying to add to his knowledge in his special department, and how cheerful and helpful to all who sought his advice! Of great personal magnetism, he was an inspiration to all brought in contact with him. But his inspiring power was stronger, wider than this; it was far-reaching, long-lasting, so that men who never saw him felt his influence, and were quickened through all their lives by his example and printed words; hearts as well as heads acknowledged his power.

Marion Sims, in many respects the greatest gynecologist of the century, has passed away, but he has left an undying fame.

SYPHILITIC PHTHISIS.

ALTHOUGH much has been said and written upon the subject of syphilitic phthisis, we are inclined to believe that many physicians have not a clear conception of what constitutes it. DR. A. SOKOLOWSKY has contributed a paper to the *Deutsche medicinische Wochenschrift*, for September 12, which points out with more than usual clearness the differences between this and the ordinary forms of phthisis.

There are two ways in which syphilitic disease manifests itself in the lungs, each of which is characterized by distinct clinical features:

1. In an otherwise favorable general condition,

and without other noticeable symptoms of syphilis, there appears in a circumscribed spot in the lung, more frequently in the right, a syphilitic neoplasm. In this limited area there are found the signs of consolidation and even of destruction of the lung, accompanied by slight cough, scanty expectoration, and rather disproportionate dyspnœa. On the other hand, the decided fever, perspiration, and diarrhœa of phthisis are altogether wanting. If, now, such a case, properly recognized, be treated with mercurials, complete recovery is possible. The cough disappears, the strength returns, and the local signs may entirely yield. The cases falling under this category are not, however, numerous.

2. In a second class of cases, including a decided majority, syphilitic processes set up in the lung in more advanced stages of syphilis, accompanied also by simultaneous, easily recognizable syphilitic lesions in other organs, as the larynx, liver, and aorta. This form corresponds very closely in certain of its clinical aspects with advanced phthisis. There are here also cough, emaciation, diarrhœa, and albuminuria. On the other hand, it is characterized by the total absence of fever. These very feeble, emaciated persons presenting the physical signs of destructive disease of the lungs and larynx have not fever, and if, from time to time, a slight rise of temperature occurs, it is never above 101.3° F., and exhibits not the slightest similarity to the hectic fever of phthisis. In strong contrast to this is the high degree of emaciation and debility, the pale, waxy, yellowish face being rather that of a patient with some malignant disease than that of a phthisical case. In like manner, night-sweats are either totally absent, or they are very trifling. Finally, the expectoration of blood is comparatively rare, at least very much more so than in common phthisis, while the dyspnœa is altogether out of proportion to the local disease.

In contrast to the cases of the first category, those of the second group, while they may be greatly improved by anti-syphilitic treatment—mercury and the iodide of potassium—never recover, the local lesions being almost unchanged, even while the general condition improves. Sooner or later, the patient perishes, with cavities in his lungs, extensive ulceration of the larynx, involving especially the true and false vocal cords, while the posterior wall is comparatively free, and with amyloid kidneys, liver, and spleen.

Such a sharply drawn picture as this should not be difficult to recognize, and, if correct, must be of material assistance in diagnosticating cases of syphilitic phthisis. We fear that syphilitic histories in cases of phthisis are too often overlooked in our examinations, and we believe that closer scrutiny and more accurate diagnosis might give more satisfactory therapeutic results.

COMA CARCINOMATOSUM.

JAKSCH has recently reported (*Wiener med. Wochenschr.*, 1883, No. 17) the case of a woman who died after an illness of four months, in which gastric symptoms and emaciation were conspicuous. Seventy-four hours before death, she fell into a condition of coma accompanied by a peculiar dyspnœa and very deep, moderately frequent respirations. During the whole time the urine contained abundantly of diacetone and acetone. The autopsy revealed extensive carcinoma of the stomach, with numerous miliary metastases in other organs. Jaksch is disposed to consider these symptoms due to a poisoning of the blood by the acetone and diacetone, the well-known cause of coma in diabetes.

IN order accurately to ascertain the whole truth and the exact views of the profession of the State of New York in reference to the Code controversy, the Central Organization of the New York State Medical Association, has just issued a proof-pamphlet of seventy-two pages, containing the names of all members of the profession in the State, classified by Counties, and then in accordance with their views on the Code question, as obtained by direct replies to inquiries, or from information obtained from the Secretaries of County Societies or others. It is intended to send this pamphlet for revision to each member of the profession whose address can be obtained, with the request to correct any error which may appear in connection with his name.

According to the most accurate information now at hand, there are 5219 physicians in the State, classified as follows:

Committed to the National Code, .	2,424.
" " New Code, . .	943.
" " having no Code, .	210.
Unclassified, ...	31.
Uncommitted, ...	1,611.

It is believed that the time has arrived for every member of the profession in the State of New York to declare himself for or against the National Code, and it is earnestly desired that those who are still uncommitted will speedily reach a decision, so that the views of the whole profession of the State may be obtained as to whether it wishes to retain its fraternal relations with the American Medical Association, and the regular profession of the United States, or to disfranchise itself therefrom by abolishing the National Code and adopting a new Code of Ethics not in harmony with it, or by abrogating all Codes.

SOCIETY PROCEEDINGS.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, November 1, 1883.

THE PRESIDENT, R. A. CLEEMANN, M.D., IN THE CHAIR.

DR. B. F. BAER related the following cases, the clinical histories of which present some points which he thinks are instructive and worthy of discussion. They are somewhat unusual in character, and it is remarkable that they all occurred within a period of thirteen days.

FORCEPS LABOR, FIFTH POSITION.

On October 17th, I was requested by Dr. —— to visit his patient, Mrs. H., who had been in labor thirty-six hours, prepared to perform craniotomy. She was a primipara, 43 years of age.

I found the patient nervous and exhausted, the soft parts dry and rigid, the os only partially dilated and the membranes ruptured many hours. The head, a large one, was in the cavity of the pelvis, and, whilst not impacted, it was nearly so. The larger portion of the head was posterior and to the left, the smaller portion, anterior and to the right. The fœtal heart-sounds were heard in the left lumbar region and nowhere else. I therefore diagnosticated a left occipito-posterior, or fifth position of Baudelocque.

I placed a vectis, and endeavored to assist rotation forwards, but failed to make any impression. I next adjusted, with some difficulty, Simpson's forceps, and by traction during uterine action, with gentle efforts at rotation, allowing the forceps to turn as the occiput rotated anteriorly, that process was finally accomplished in about two hours of hard work. I now removed the blades, and after finding that the head could not be otherwise delivered, I readjusted the instrument and assisted in extension of the head, delivering a living child said to have weighed twelve pounds. There was no laceration of the perineum. Both mother and child have done well. The case is interesting because of the age of the primiparous patient, and in the position of the occiput, which is rare.

ARM PRESENTATION; PODALIC VERSION.

On October 23d, Dr. —— requested me to see a patient with him, a girl sixteen years of age—a primipara at full term—in labor about twenty-four hours, and trunk presenting.

In general appearance she resembled more a child of twelve than a girl of sixteen. The external genitals and vagina were small and undeveloped. The abdomen was greatly distended, globular, and fluctuating. Palpation was of only negative diagnostic value, probably on account of the large quantity of amniotic fluid. But I thought I detected the head in one iliac fossa, and the breech in the other. Auscultation revealed the fœtal heart-sounds, feebly heard in the right iliac region. The upper portion of the vagina was distended by a large, protruding, "bag-of-waters," and the os uteri was fully dilated. I could only slightly touch the presenting part, which was entirely above the superior strait. I detected what I thought to be a limb, and from what I had learned previously by inspection, palpation and auscultation of the abdomen, I believed it to be an arm. I then dilated the orifice of the vagina preparatory to passing my hand, should that be found necessary, after rupture of the membranes, which I now did, and found a shoulder presenting and an arm on the verge of passing the os. This I arrested, and made version by the feet. I preferred this to version by the vertex, because I deemed it easier and less dangerous to both mother and child to effect delivery in that manner, than to apply the forceps in this special case. The child was alive, but feeble. The body passed through the narrow vagina very slowly, and only after pressure on the fundus of the uterus, until the head reached the floor of the pelvis. Here, by assistance, the occiput rotated forwards and the head was arrested. Flexion of the head could not be made to occur by supra-pubic pressure, and by pressure upon the nape of the neck, whilst a finger or two acted upon the anterior surface of the head through the rectum. I then quickly adjusted the forceps, and carrying the handles forward with the body of the fœtus, made flexion and delivered a living child. There was not the slightest laceration of the perineum.

The uterus did not contract well; and although ergot was administered, and time given for the organ to recover its tonicity (thorough kneading being used meanwhile), when the placenta was expelled a smart post-partum hemorrhage followed. This was easily controlled by the application of pure vinegar to the cavity of the uterus, injected by means of the long-nozzled uterine syringe, which holds about half an ounce. I prefer this method of introducing the vinegar to any other, for the reason that it is more easily and thoroughly applied. I carry the nozzle, guided by the index-finger, as in the introduction of the sound, into the uterine cavity, and project the vinegar, without force, over the surface. This can be repeated if necessary, which is seldom. Too much praise cannot be accorded Prof. Penrose for his earnest advocacy of the use of vinegar in the treatment of post-partum hemorrhage, the result of uterine inertia. In my experience, it has never failed to secure firm and continuous contraction, when properly applied. It is simple, antiseptic, and harmless.

ARM PESENTATION; PODALIC VERSION.

October 29th Dr. —— sent for me, stating that he had a case of shoulder presentation, that the membranes were ruptured, and the os only partially dilated. He had attempted to make version by the feet, and had brought down an arm in mistake for a foot. I found a primipara, æt. 22 years, illegitimately pregnant, at full term, feverish and excited. A large, fat right arm occupied the vagina, and the shoulder was jammed into and projecting through the os, which was firmly contracted around it. It was a dorso-posterior position, and the head was in the right iliac fossa. All the liquor amnii had been drained away, and the uterus was closed tightly around the child, which was apparently dead.

We administered ether, and I at once began an effort to bring down a foot, deciding that version by the vertex here could not be made, because the arm could not be returned to the uterine cavity, and, even if the arm had not been down, I feel sure that the bipolar force would not have been great enough to have brought that head to the superior strait. But to get through the narrow vagina and rigid os, which were filled already by the arm and shoulder, was one problem, and another, apparently greater one, was the turning of the large child in a contracted uterus. An attempt was, however, not only justifiable, but obligatory, for the sake of the child, of whose death we were not sure. Then, embryotomy, in a case of this character, would, I believe, have been attended with greater danger to the mother than version. I gradually inserted my hand and carried it into the uterine cavity, and with it I tried again to replace the arm, but failed. My hand was now so benumbed that almost all sensibility was lost. However, I finally reached the feet, selected the uppermost or left one, and began my efforts at version, assisting all my internal manipula-

tions, of course, by placing the external hand on the abdomen, and acting with it on the opposite pole of the child. When I made traction on the leg, the arm advanced further into the vagina, and it now seemed that I should certainly be compelled to give it up, the difficulties appeared so great. But patience and perseverance are cardinal virtues here, and by exercising them to my utmost capacity, I succeeded in getting the foot and leg into the vagina, where I secured them with a fillet. I now gave this to Dr. ——, and whilst he made traction upon it, I pushed upon the shoulder, and succeeded finally in revolving the child on its long axis, causing the arm to ascend and the leg to occupy its place in the vagina. The remainder of the delivery was that of a difficult breech case, where traction on the child and pressure upon the fundus of the uterus are imperative. The child was dead. The mother reacted well, and has not presented an untoward symptom. There was slight laceration in the sulci on either side of the vagina, not through the cutaneous surface, and not enough to require sutures.

BREECH PRESENTATION.

Twenty-four hours later, on October 30th, my friend Dr. Wm. L. Taylor requested me to see with him Mrs. X., a primipara, thirty-five years of age, who had been in labor twenty-four hours, the breech presenting in the left sacro-posterior position. The membranes had ruptured twelve hours previously, the os was rigid, and only slightly dilated, and the breech was impacted in the superior strait, which seemed to be narrow. The patient was short of stature, fat, and had a small vagina. It was thought that the child was dead, but of this we were not sure.

Was there any use in waiting longer for nature to effect delivery? We decided that there was not, and, I believe, correctly. An attempt at traction was made by acting on the thigh, but it was futile. I passed my hand with great difficulty into the cavity of the uterus, which closely surrounded the child, and endeavored to reach a foot, but found that the legs were extended; and it was only after I had advanced my hand absolutely to the fundus of the uterus that I secured the desired member. The uterine cavity was now so rigid and full that it appeared impossible to flex the leg, and extend the thigh. But here perseverance again succeeded, and the leg was brought into the vagina. Delivery was finally consummated by the greatest effort. The child was dead, and from appearances had been so for some hours, as Dr. Taylor had suspected. The mother recovered, as after an ordinary labor.

PUERPERAL CONVULSIONS.

A few days before, October 21, there entered my service at the Maternity Hospital a girl, eighteen years of age, illegitimately pregnant, and near term. She presented a depressed appearance, and was pale and puffy from œdema. Her urine was examined at once, and found to contain a large quantity of albumen and some casts. Her labia minoræ were so œdematous that she walked with difficulty.

She was placed upon a treatment consisting of Basham's mixture, digitalis, laxatives, and warm baths, with good food. On the 20th, the nymphæ were so greatly distended that I feared obstruction to delivery, which was about to take place; I therefore made about a dozen small punctures over their surfaces. This was followed by a very free discharge of serum, so that in the evening the labia were reduced more than one-half. During the night, labor occurred, and she was delivered naturally at seven A.M. on the 21st, having been attended by my assistant, Dr. J. P. Pyle. There were no symptoms during the labor nor immediately after it to attract attention, but before leaving her, he administered thirty grains of the bromide of potassium as a safeguard.

At 9 o'clock he was hurriedly called, and found her just recovering from a convulsion. He at once sent for me, and began the administration of chloroform. But before I reached her, at 10 o'clock, she had had two more seizures, and just as I entered the room she went into another, which was one of the most terrific convulsions I have ever witnessed. I immediately opened a vein and allowed about sixteen ounces of blood to flow. I will confess that I did not want to take blood from this patient, because she was in such an apparently low condition. The bleeding did not seem to have the slightest effect, for very soon after it she had another convulsion fully as severe as the one preceding. Since the first attack there had been given, per rectum, twenty grains of the hydrate of chloral and forty grains of the bromide of potassium, and, per os, one-fourth of a grain of elaterium. But the convulsions continued to recur, unless the patient was kept constantly under chloroform, and coma was deepening with each attack. I now injected, hypodermatically, three-fourths of a grain of the sulphate of morphia. This was at 11.30 A.M. She did not have another convulsion, although no more chloroform was administered until 2 P.M. At this time she had a slight one, and at 2.30 another much more severe, when I repeated the dose of three-fourths of a grain of morphia. After this she had no more convulsions. The dose of elaterium was now repeated, and the kidneys stimulated by large doses of saline diuretics, administered by the rectum. The bowels moved freely and repeatedly soon after the last dose of elaterium was given, and the kidneys responded promptly; but the urine became nearly solid, when the test for albumen was applied, and casts were so numerous, and of such a character, that an unfavorable prognosis was pronounced by the competent microscopist who made the examination. The patient, however, came gradually out of the profound coma, but did not recover consciousness until nearly three days had elapsed, becoming at times wildly delirious and maniacal. As soon as she could swallow, I resumed the administration of Basham's mixture and digitalis, and on the next day added quinine and ergot, the latter especially to restore tone to the capillaries, and thus assist in improving the condition of the brain. Milk and beef tea were given largely. The patient will leave the hospital to-morrow, although her urine still contains albumen in considerable quantity.

If uræmia is ever the cause of eclampsia (which is not settled), this case presented the kidney state which is usually found in cases said to be of that origin.

Since it is *à propos*, I will relate a case which was probably not of uræmic origin, because the urine did not indicate the slightest disease of the kidneys.

PUERPERAL CONVULSIONS.

My friend, Dr. J. B. Deaver, asked me to assist him in the delivery and treatment of a case of convulsions. The patient was eighteen years of age—a primipara, and unmarried. The occiput was posterior and in the hollow of the sacrum. The first convulsion occurred after the head had passed the superior strait, and it was a very severe one. Dr. Deaver immediately bled, and very freely. Another convulsion occurred soon after the bleeding, although chloroform was administered and chloral given by the mouth. When I reached her, she had had three attacks, and was profoundly under the influence of the anæsthetic, and, of course, could not be convulsed in that state. I adjusted the forceps and delivered, with the occiput posterior, being unable to rotate it anteriorly. The anæsthetic was now removed, and not long after another violent convulsion

occurred. I now injected two-thirds of a grain of morphia under the skin. She did not have another seizure, and made an uninterrupted recovery. As stated above, there was not the slightest evidence of disease of the kidneys, either before or after labor. The cause here was reflex—the patient being predisposed by a depressed mental condition, etc.

The first indication to be met in the treatment of puerperal eclampsia should be to control the convulsions. I do not think it will be gainsaid that the prognosis becomes less favorable with each recurrence. I believe that morphia, administered hypodermatically in a large dose, and repeated, if necessary, is one of the most efficient, if not the most efficient, means which we possess for that purpose. In the next case which I am called to treat I shall give one grain. I will bleed, if I think that it is indicated, and shall use chloroform; but I will certainly give the morphia. I will then attend to elimination through the bowels, kidneys, and skin. Dr. Clark, of Oswego, N. Y., first brought the morphia treatment before the profession, in a fearless and excellent paper, published in the *American Journal of Obstetrics* for January, 1880, which is worthy of study.

DR. ELLIOTT RICHARDSON thought the extent of dilatation of the cervix a very important point in considering the advisability of version in shoulder presentations. When the fœtus is in a transverse position it cannot descend, and as the cervix dilates it slips upward on the neck and chest of the child, and thus puts the vagina in a condition of longitudinal tension and consequently of narrowing. Any sudden or extreme attempt at dilatation of the vagina, when in this condition, involves a great risk of laceration. In Dr. Baer's case the narrowness of the os uteri was a favorable circumstance for podalic version.

There is a wide difference in the treatment of puerperal convulsions, as practised in this country and in Germany. Carl Braun strongly discountenances bleeding, and recommends chloroform with the administration of benzoic and citric acids to assist the action of the kidneys. He considers that the prime object is to put the body at rest.

DR. W. T. TAYLOR thought that, in Case 2, if the method of Dr. Wright, of Cincinnati, for the correction of the shoulder presentation by converting it into a vertex had been tried, the difficulties and dangers of a version by the feet might have been avoided.

He does not think bleeding should ever be omitted in the treatment of puerperal convulsions in plethoric patients. Bleed freely and give chloral in large doses by the rectum. He thinks the use of opium should be preceded by bleeding.

DR. ALFRED WHELEN has tried one-quarter grain of nitrate of pilocarpine hypodermatically after bleeding; the result being successful. The use of the pilocarpine did not seem to be followed by serous effusion. In one case in which no treatment of any kind had been used, an autopsy showed all the serous cavities filled with effusion. He thought the arterial tension, consequent on the convulsion, was the cause of the exudation.

DR. R. A. CLEEMANN had tried all plans, and none of them were certainly successful; every method would fail at times, and any method will be followed by recovery. He thinks bleeding should be tried in every case to remove the vascular tension which is the great source of danger.

DR. B. TRAUTMANN had under his care a primipara, plethoric, who was suffering from puerperal convulsions; she was bled, a large dose of calomel was given, chloral was administered, and pilocarpine was injected, but all without effect: the patient died. In another case the urine contained fifty per cent. of albumen with casts, and no convulsion occurred. What is the relation between albuminuria and convulsions? Is the origin of the convulsion in the nervous system, and the albuminuria a result?

DR. H. F. BEATES.—The presence of urea in the blood being generally considered a prime factor, most of the forms of treatment have reference to its elimination. Bleeding should be very free to act in that manner, and if it is prompt and free, it will be followed by improvement; pilocarpine acts as an eliminator of urea, by the skin, thus relieving the kidneys and the system. He had treated two cases by this method, and both had recovered.

DR. PHILIP M. SCHIEAT had recently under his care, a primipara, aged 25 years; she had convulsions for four hours; chloral and bromide of potassium had been given freely, but with no effect; a hypodermatic injection of three-quarters of a grain of morphia sulphate was followed by quick relief; she was very plethoric, but there was no need for bleeding after the use of the morphia.

DR. BAER, in Case 2, had considered version by the vertex, but thought that he could deliver more quickly and with less danger to both child and mother by means of podalic version. He considered elimination a false principle in the treatment of puerperal convulsions. First stop the convulsions; eliminate afterwards if there be any necessity for it. How much elimination can be effected by drawing twenty or even forty ounces of blood? The majority of these patients need all of the blood they have; they have none to spare. There is a neurasthenia at the bottom of these attacks. The patients are generally nervous and depressed from circumstances connected with their physical and social condition. Dr. Penrose, in his lectures at the University, taught bleed—bleed—every case that was bled sufficiently, got well; every case that was not bled died. Dr. Carson's lecture followed immediately after that of Dr. Penrose, and he was as bitterly opposed to bleeding as Dr. Penrose was enthusiastic in its advocacy. He has been afraid of pilocarpine, because its action, once established, cannot be controlled; he thinks, however, that the effusions observed have been caused by the convulsions, and not by the remedy. Morphia, used hypodermatically, is the remedy upon which he puts dependence; it will control the convulsion. Any medicine administered by the mouth or rectum must be of slow and uncertain action, because of the slowness of absorption from the alimentary tract.

DR. BEATES reported a case of

DIPHTHERITIC PARALYSIS

in a child of eight months. The muscles of the neck were affected, and resulted in extreme flexibility of the neck, the head rolling all about. Death resulted apparently from paralysis of the phrenic nerve.

NEW YORK NEUROLOGICAL SOCIETY.

Stated Meeting, October 12, 1883.

THE PRESIDENT, DR. WILLIAM J. MORTON, IN THE CHAIR.

DR. LEONARD WEBER read a paper on

THE NEUROTIC ORIGIN OF PROGRESSIVE ARTHRITIS DEFORMANS.

Having briefly recapitulated the symptomatology and etiology of arthritis deformans, the reader proceeded to develop his personal views concerning the nature of the disease in question. He said that among the comparatively large number of cases of arthritis deformans he had seen in the course of the last twenty years, he could not but recognize sorrow and grief,

fright, irritation and exhaustion of nerve-centres by sexual indulgence and a dissolute life as leading factors, just as potent in producing the disease as rheumatic influences, if not more so. Again, remembering the symmetrical appearance and progress of the disease in most cases, no more plausible explanation seemed possible than the supposition of causes located in the central nervous system. The neuralgic and trophoneurotic symptoms also supported this view, though it was not to be forgotten that in a spine stiff and deformed by arthritis, there might easily occur changes of innervation, producing neuralgias and trophoneurotic changes secondary in character.

Finally, the negative results he had had in treating polyarthritis deformans after the usual anti-rheumatic method, with iodides, colchicum, etc., and, on the other hand, the very positive results obtained in similar cases by the galvanic treatment of the central nervous system, combined with a generous diet and the persistent administration of cod-liver oil and iron, led him to believe in the neurotic origin of the disease in many cases. It was through the repeated failure of the old method that he first became convinced of the erroneousness of the conventional opinion of the rheumatic or gouty origin of this formidable malady. Up to the present, no autopsies had been made with reference to the condition of the nerve-centres in this disease, and it would be a fit subject for future research to find the changes in the cord, presumably in the anterior horns, which might induce certain forms of arthritis deformans.

With regard to the main features of the disease, he had this to say, as a rule, it began and developed very slowly, without any other symptoms, at first, but pains in one or more joints, which came and went either spontaneously or after exertion. Not infrequently the patient complained at this early stage of an unusually tired feeling in the joints. The pains were neuralgic in character, circumscribed or diffused through the limb. In the peripheral form, the joints of both hands and feet; in the central variety, the hip, knee, and spine were the parts affected. In the course of time a great deal of stiffness and discomfort was experienced. The joints became enlarged, and became unshapely by the proliferation of hard, osseous protuberances on the outer surface of the swollen epiphyses, and creaking or cracking in moving or palpitating the joints was perceptible to the patient as well as to the physician. The adjacent soft parts, particularly the muscles, showed in a comparatively early stage of the disease a degree of atrophy not at all commensurate with their passive condition alone, but much more likely due to peculiar nutritive changes of neurotic or myotic origin.

In the peripheral form the disease affected the joints almost always symmetrically; in the central form, the advance was irregular. In one case he had seen it remain stationary in the hip-joint for many years, but attacking some joints of the fingers and toes at last. In another case, a female patient about thirty-five years of age, the upper part of the body only was affected. He has now a case under observation where nearly all the joints of the body were badly affected when he first saw the patient, who had been a helpless cripple for many months. The disorganization of the shoulder, knee, and particularly the hip-joint, leads often to a considerable shortening.

In one of his cases still under observation, the shortening of the lower limb amounted to nearly three inches.

In the spinal vertebræ ankylosis was more quickly developed by the disease than in other parts of the body. One of his patients could neither bend nor turn her head when he first saw her, the entire spine being stiff, but there were no symptoms of compression or even remarkable irritation of the cord. The disease was slowly but steadily progressing; while it might remain stationary for a length of time, exacerbations were sure to follow. Fever or other great constitutional disturbances he had not noticed in its course. In a female patient, æt. 37, he found the urine to have a specific gravity of 1026, containing some sugar and phosphates in abundance. Her mother had diabetes, and was a sufferer from arthritis deformans at the same time.

The following cases were selected from his records as illustrative of the points he wished to bring out.

CASE I.—Mrs. M., æt. 47, American; no syphilitic or hereditary taint, but sister is reported to be a sufferer from chronic rheumatism. Married early in life; went on the stage, and, as a somewhat prominent actress, led an active and varied life, experienced many changes of fortune, travelled a good deal, and never hesitated to expose herself to wind and weather, yet always enjoyed good health until two and a half years ago, when, after a premonitory period of worry and depression of spirits caused by the loss of the last piece of property she owned, she experienced pains in both wrists and elbow-joints, followed by swelling and distortion of the same. Hands and feet soon followed, and when I saw her first, on Feb. 27, 1883, she had not a joint that did not creak or crack or was not out of shape, except those of the clavicle and the lower jaw. The knees and spinal vertebræ were in the worst condition and the most painful. Standing or walking, even with support, was out of the question. Her urine contained phosphorus; no albumen. Sleep and general nutrition bad; bowels irregular; no treatment had so far done any good, but the disease had made rapid and steady progress. Ordered to take of propylamine (trimethylamine) ʒj, aq. ʒviij, oleosacch. cibi ʒij, a tablespoonful ter in die before, and two pills of ferr. sulph. and potass. carbon. after, each meal; good food, and a tablespoonful of cod-liver oil three or four times a day. Galvanism to spine and the cervical ganglia of the sympathetic three times a week. The local and general improvement has been so satisfactory that she is now able to get up and around with the help of a cane, and to do light work with her hands. The pain and swelling and distortion of joints are much less; sleep and nutrition greatly improved.

CASE II.—Mrs. K., æt. 34, German; married twice, had two still-births and two abortions; second husband had syphilis, and died of phthisis. Patient presents no signs of either disease; no hereditary influences. In 1877–78, severe attacks of bronchitis that troubled her the whole winter, but eventually got well without any apparent damage to the lungs. After some years of trouble, anxiety, exposure, and want, a deformans broke out two years ago, with pain and swelling of small joints of hands and feet, soon spreading to one knee, shoulder, and hip-joint. The disease was preceded by severe headaches, from which she suffers yet occasionally, but less violently. Some of the joints present a gelatinous feel, and several nodules of the above description can be felt beneath the integuments of her arms. No pain on pressure over sternum, clavicle, or tibia. Neither specific nor anti-rheumatic treatment, so-called, was of any service, but the disease has been very tardy in its progress, and the disfigurements of the joints are not to be compared to those of Case I. She has always been able to walk, though not without pain, and from time to time has been confined to her room. Appetite and general nutrition not good. The treatment described in Case I. was commenced in January, 1883, and carried out pretty regularly up to the present time, except as to the application of electricity. The result thus far has been satisfactory; further progress of the disease

has been stopped; pain, swelling, and disabilities of locomotion are much less.

CASE III.—Mrs. K., æt. 35, American, married, multipara. Father in good health; mother suffering from diabetes and arthritis deformans. Patient well built and nourished; living in good circumstances; has been for some years very unhappy in domestic relations, and been often deprived of rest and sleep, and been otherwise maltreated. After a series of premonitory symptoms, such as hemicrania and neuralgia in the upper extremities, she showed the first symptoms of the disease in the joints of fingers, wrists, and shoulders about a year ago. Her urine contains phosphates (largely) and a little sugar. The affection has made no great progress as yet, and the treatment has not been carried out well enough to be of great service, owing to the irregular attendance on the part of the patient.

CASE IV.—Mrs. H., æt. 55, multipara; no hereditary taint; no apparent cause beside a good deal of anxiety and grief on account of the persistent ill-behavior of her only son. First symptoms in small joints of fingers and toes, five years ago. So far she has not experienced any great inconvenience from her affliction, but as often as she makes up her mind to take the propylamine mixture and cod-liver oil for some time, great relief follows as to pain and swelling.

CASE V.—Mrs. S., æt. 65, German, married, multipara; no hereditary taint, but a good deal of exposure to rheumatic influences in her younger days. First attack in her right hip-joint, fifteen years ago, which led, in the course of time, to a shortening of nearly three inches, and now to complete ankylosis. No other suffering until recently, when several small joints of her hands and feet became affected, and she had to take to her bed. Various sorts of cures were applied, to no purpose; for the last three months she has taken propylamine and the compound syrup of the hypophosphites, with the result that she is able to be about again, and that no other joints have been attacked.

CASE VI.—Mr. G., æt. 60, Austrian, clergyman, single; of good constitution, and no hereditary taint. He served as a missionary in his prime; travelled extensively in South and Central America. He was, of course, exposed to the severe effects of unhealthy climates, and suffered many hardships besides. He had several attacks of rheumatism, of which he got well, but eight years ago it settled in his right hip and left knee; and when I first saw him, five years since, he was in constant agony, confined to his bed for many months, and the above joints presented all the symptoms of advanced arthritis deformans. Some of the joints of his hands and feet had also become recently affected. His urine contained albumen in considerable quantities; there were amblyopia—the ophthalmological examination showing the affection of the retina often found in Bright's disease—and atheroma.

By the use of the iodides and other remedies, he was but little relieved; but two seasons at the hot springs of Virginia removed the severe recent affections of the joints, relieved his kidney trouble, and considerably improved his eyesight. The old affections of hip and knee remained as before, but ceased to give him much trouble, so that he was able to be about and attend to his clerical duties.

DR. E. C. WENDT, in opening the discussion, said that he had seen a number of cases of arthritis deformans, mostly in hospital practice, all of which had, under the usual plan of treatment, gone on from bad to worse. He had also seen one of Dr. Weber's cases, in which a marvellous result had been obtained, in a comparatively short time, by an entirely different plan of treatment. He thought the value of Dr. Weber's interesting paper lay mainly in the therapeutic suggestions which it contained. If other observers corroborated the ideas here advanced, a decidedly progressive step would have been taken. He thought it was important to elucidate the causation of the disease: mere symptomatic treatment was quite irrational.

DR. DANA remarked that the few cases seen by him had not illustrated the neurotic origin of the disease. In New York, he was of the opinion that the disease was rarely met with in private practice. He had seen only a few cases in hospital and dispensary service; this was even true in the Marine Hospital for Sailors, where rheumatism abounded. He recollected having seen one aggravated case: the patient was an old woman, some seventy years of age, who had suffered from the disease for sixteen or seventeen years. It began in the vertebral column, and gradually involved the hips, knees, and toes. She was so helpless, that in order to evacuate her bowels it was necessary to place her in the horizontal position over a pail. The patient had Bright's disease and died of apoplexy. Upon post-mortem examination, deposits of urates were found in the joints of the great toes. The patient was poor and surrounded by all the conditions favorable to the development of the disease.

Dr. Dana said he had seen some women of a neurasthenic type, women who had suffered from functional nervous disturbances, who developed a kind of inflammatory swelling of the fingers, so that in one case the hands became almost useless. He did not know but that later on in life these cases might develop into arthritis deformans; and, if so, they would illustrate the theory advanced in the paper. In considering neurotic inflammations of joints, Dr. Dana thought the relation of the trophic nerves to them, if there are any trophic nerves, should not be lost sight of. Never, so far as he knew, have we found any articular disease following functional nervous trouble. The nervous difficulty must be organic. In no experiment upon animals, except where an organic lesion of the spinal cord has been produced, have we been able to produce arthropathies.

DR. WENDT did not know that the author's paper contained any evidence that the disease was developed from an organic lesion of the spinal cord. If there had been such grave central disease of the spinal cord, improvement could not have been so rapid. He thought the neurotic condition was not the ultimate, but an intervening cause. If we would go back still further into the history of these cases, he thought we would find that there was first a disturbance of nutrition, after which the neurotic condition developed.

DR. BURRALL wished that he could add something to our knowledge of this subject. The disease was one we were continually meeting. It seemed to him to be an arthritis resulting from trophic changes. In two cases which he could now call to mind, these changes resulted from worry. One case had gouty trouble. There was no uric acid found in the urine of patients suffering from arthritis deformans. As far as therapeutics were concerned, he knew of only two remedies. The two remedies he would hope to derive beneficial results from the use of, were arsenic, which is a nervetonic, and eupatorium perfoliatum (boneset).

THE PRESIDENT felt like adding a word in regard to the practical part of the paper. He had not seen many cases of arthritis deformans in private practice; he could only recall five. It was probable that most cases were seen by the general practitioner. In the first four he had met with unsatisfactory results; but in the last, becoming convinced of the fruitlessness of the anti-rheumatic plan of treatment, he had administered cod-liver oil, iron, and static electrization, with great benefit to the patient. He was of the opinion that the disease occurred most frequently in the so-called neurasthenic.

It was interesting to note that the first advocate of the neurotic origin of the disease was an American, Dr. J. K. Mitchell, the father of Dr. S. Weir Mitchell, of Philadelphia. At a very early date, 1834, Dr. Mitchell announced it as his theory, that acute, subacute, and chronic rheumatism were diseases of the spinal cord. The neurotic theory of the origin of the disease in certain subacute forms was a very attractive one. He was prepared to admit, as an argument in its favor, that the ordinary anti-rheumatic treatment fails to relieve the patient. In the next place, there is a well-understood relationship between the disease in question and well-recognized nervous ailments. We have only to call to mind the arthropathies of the myelitis of traumatic neuritis and of certain hemiplegias, to find a defensible relationship to the changes in the joints characteristic of arthritis deformans.

DR. DANA remarked that, as interesting as it might be to claim the theory of the neurotic origin of arthritis deformans for America, it was difficult to see how the information afforded by the President's remarks made it clear that such really was the case. The author of the paper had laid special stress upon the idea that arthritis deformans was an essentially different disease from acute or chronic rheumatism. Hence Dr. Mitchell could not be credited with the origin of this theory, as his claims concerned only acute and chronic rheumatism.

THE PRESIDENT did not think that Dr. Mitchell's claims were thus narrowly restricted. It was doubtless true, however, that these claims should not have covered all forms of rheumatism as known at his day.

DR. DURRALL incidentally called the attention of the members of the Society to the fact that there was at the present time a case of Charcot's disease in the wards of the Presbyterian Hospital of this city. Dr. Charcot claims that Dr. Mitchell was the first to associate joint disease with the central nervous system.

DR. WEBER, in closing the discussion, said that he was glad to have learned, from the remarks which had been made, that it was well to have brought the subject before the Society, and that he had come forward none too soon with his views upon the subject.

NEW INVENTIONS.

A NEW AIR COMPRESSOR FOR THE ATOMIZER.

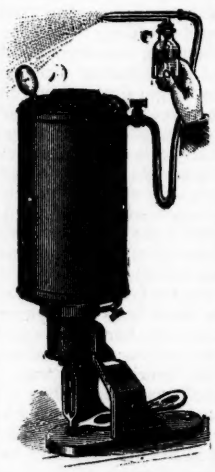
BY CARL SEILER, M.D.,
INSTRUCTOR OF LARYNGOLOGY AND LECTURER ON DISEASES OF THE THROAT AND NOSE AT THE UNIVERSITY OF PENNSYLVANIA.

THE use of atomized liquids in the treatment of diseases of the upper air-passages has become of late almost universal, and has in a great measure supplanted the older methods of applying remedies to the mucus membrane of the throat and nose; and in modern surgery the carbolic acid spray plays an important part. This atomization, or spray, as it is commonly called, is produced by forcing a current of air, or steam, through a tube, which, in passing out from the small opening at the end, rushes past the opening of another tube, the end of which is below the level of the liquid to be atomized. In doing so the current exhausts the air in the second tube, thus causing a rise of the liquid until it appears at the opening, when it is carried along with the current of air in a finely subdivided state; or else the tube is fastened air-tight into a vessel containing the liquid and the air is forced by another tube partly into the bottle and partly into the upper end of the tube. The pressure of the air within the vessel causes the liquid to ascend, and, coming in contact with the air-current, is carried out of the contracted end of the tube in the form of a spray.

The air-current should be a continuous one, and it is therefore necessary to compress the air in some convenient chamber, whence it flows through the atomizing tube. This is accomplished in a variety of ways, the most common of which is the well-known double-bulb atomizing hand-ball, made of rubber, or the force may be obtained from a small steam boiler, as is the case in the steam atomizer.

The hand-ball has the great disadvantage that the operator has both hands employed, one in holding the tube and the other in working the ball, so that he cannot direct the spray in the desired direction, nor control the motion of the tongue of the patient; and further, that the long-continued use becomes very fatiguing to the hand working the ball. The steam atomizer, besides being very complicated and easily deranged, cannot be used to throw the spray downward into the larynx nor upward into the naso-pharyngeal cavity.

Having experienced these difficulties for many years in my practice, I was grateful when, three years ago, I obtained from Mr. J. Elliott Shaw a Burgess air compressor, which ever since has given me great satisfaction. This apparatus, which is easily worked, compact in form, and light in weight, is in its general form shown in the cut. It consists of a small air-pump worked by a treadle and surmounted by an air-chamber. The pump cylinder is made on an arched stand, and contains a piston having a valve opening upward. The piston is connected to the treadle by a forked connecting rod, and is moved by a slight and easy motion of the foot. The upper end of the pump cylinder is closed, with the exception of a valve aperture opening into a small or sub-air chamber, which is securely attached to the large air reservoir made of heavy tin, and which is nine inches in diameter and fourteen inches high; connection is made between the sub-air chamber and the reservoir by a small brass tube, the air being admitted or confined by a stop-cock. Near the top of the reservoir there is another stop-cock, to which is attached a flexible rubber tube leading to the atomizer. In the upper end near the edge of the reservoir is secured a small spring pressure gauge, indicating by the movement of its hand on the dial the pressure to the square inch of the air contained in the apparatus —from one to twenty pounds. The whole instrument stands thirty-two inches high and weighs sixteen pounds.



Thus from this description it will be seen that we can compress the air to any desired pressure under twenty pounds, and draw it off from the reservoir as it is needed for making applications to the throat or nose with the atomizer, replenishing the air by a little pumping when the pressure gets too low; and I have found that when filled at a pressure of from ten to twelve pounds there is enough air to give a spray, with a good atomizer, for ten minutes, or to make application to three or four patients in succession without pumping. When used for the carbolic acid spray, a gentle movement of the treadle will keep up the current at the desired pressure for an indefinite length of time, and in this respect the apparatus is superior to the steam atomizer, for in it the water in the boiler becomes exhausted very soon and must be replenished, causing an interruption of the spray for several minutes.

OBITUARY.

JAMES MARION SIMS, M.D.

IT is with feelings of profound sadness that we announce the death of Dr. J. Marion Sims, which took place, suddenly and unexpectedly, on Tuesday morning last, November 13th, at his residence in Madison Avenue, New York. His health had been somewhat delicate for some time past, indeed, ever since the severe attack of pleuro-pneumonia two years ago, which came very near carrying him off; but no one could have supposed from his appearance that his life's end was so close at hand. He had been busily engaged for some days past in making his preparations to sail for Europe next Saturday to spend the winter abroad, and it was only the evening before he died that he made some professional calls. In the early morning he awoke, and after writing a few lines and taking a drink of water, he lay down and, apparently, was soon asleep. He breathed heavily, however, and his wife presently perceived that there was something wrong about him, and before she could summon their son, Dr. Harry Marion Sims, life was extinct. An autopsy showed the immediate cause of death to have been a degeneration of the muscular fibres of the coronary artery, with sudden obstruction of the circulation.

The demise of this great and good man will fall like a pall upon the heart of the American medical profession, of which he was so great an ornament, which he enriched so much by his labors and his genius, and by which he was so universally beloved and venerated for his many noble qualities. His loss will be deeply felt and will excite widespread sympathy. When such a person dies the world is conscious of having lost a man. When the history of American medicine shall be written, one of its brightest pages will be the account of Dr. Sims, a name of world-wide fame, as enduring as the hills and valleys of South Carolina, his native State.

Born on January 25, 1813, in Lancaster District, he received his English and classical education in the South Carolina College, at Charleston, and then studied medicine, graduating from the Medical College of the Palmetto State in 1832, and from the Jefferson Medical College in 1835. Thus equipped with a more than ordinary amount of knowledge, and impelled by a lofty ambition to excel in his profession, he selected Montgomery, Alabama, as his future home, and it was there, in the midst of genial and appreciative friends, in a delightful cotton region, blessed with a charming climate, and enlivened by the song of the mocking bird, that he laid the foundation of his future fame and usefulness.

Meeting with several cases of vesico-vaginal fistula, which had repeatedly and in vain appealed for relief to other practitioners, it occurred to Dr. Sims that an operation might be devised, by which a permanent cure of this distressing affection might be effected. For this purpose he opened a private hospital with a capacity of sixteen beds, conducted solely at his own expense. His patients were all young colored slaves, all primiparæ, who, as they were of no use to their owners, willingly placed themselves under his charge. He had, strange to say, originally no fancy for obstetric and gynecological practice. His practice was of a general nature, largely, however, partaking of surgery.

The first two or three cases of vesico-vaginal fistula that came under his observation were summarily dismissed, because, from all he had seen and read upon the subject, he considered the affection as utterly incurable. A third case, brought to him soon after the last, would have shared a similar fate, had it not been for a circumstance that changed the whole tenor of his life, by inspiring him with the thought which thus enabled him to lay the foundation of gynecology, of which he will, in all time to come, be regarded as the scientific father. A lady fell from her pony, and striking the sacrum, dislocated her uterus, causing intense agony. Called almost immediately after the accident, he placed her upon her knees, so as to elevate the pelvis, and depress the head and chest, and he found, to his surprise as well as joy, that the organ at once returned to its normal position. New light had burst upon his vision in reference to the operation for vesico-vaginal fistula; atmospheric pressure, with the slight aid of his fingers, had done the work, and he was not slow to take advantage of what proved to be a most important discovery. He now set about inventing new instruments, new needles, and new sutures, for the more secure closure of these horrid and disgusting fistulæ. Sims's speculum is used in every part of the civilized world, and silver sutures enjoy an equally great popularity, although they are not indispensably necessary to the success of such operations.

He now had often half a dozen cases of vesico-vaginal fistulæ under treatment in his little hospital at one time. In a letter, written November 6, 1882, he says: "When I began this work I was thirty-three years old, full of life, energy, endurance, and enthusiasm. I was so sure that I could cure every case in a few months that I proposed to the masters of the unfortunate young women to keep them at my own expense if they would clothe them and pay their taxes, and promised not to do anything that could endanger their lives or render their condition worse. As they were entirely profitless to their owners, I easily got control of them, and they were only too happy to come with the hope of getting rid of their disgusting infirmities. Keeping so many patients at my own expense for four years impoverished me, and, what rendered matters worse, my own health gave way. Convinced that I could not obtain relief in the South, I was compelled, in 1850, to go North. When I reached New York, I weighed only ninety pounds, and my disease harrassed me until 1856. I may mention the fact that when I began my experiments, my professional brethren in Montgomery were all ready to come and help me, for they thought with me that I was on the eve of a great discovery; but, when they saw only failure after failure, they became tired of it, and in the third and fourth years I could get hardly any one to help me. During the last year my principal assistants were the patients; and they had always eagerly looked forward to the time of having their operations repeated, often contending with each other who should be next. All the operations were performed without an anæsthetic. Indeed, I had been at work a year before the introduction of ether."

Thus, at length, in 1849, after many trials and failures, Sims triumphed over all obstacles and placed his method upon a scientific and enduring basis. Upon one of his patients he performed not less than thirty operations, before he finally succeeded in effecting a complete riddance of her loathsome infirmity. It is difficult to say which most to admire in this case, whether the fortitude of the poor sufferer, or the patience, perseverance, and skill of the great surgeon. It affords an example of sublime devotion, of which history records but few instances. Dr. Sims published the first account of his operation in THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES, for January, 1852. It was prepared while he was confined to his bed, at a time when he was considered hopelessly ill. It speedily attracted universal attention.

In 1853, Sims removed to New York, where, during the following year, he founded the Woman's Hospital, the first institution of the kind on this continent, exclusively devoted to the treatment of the diseases of women.

In this undertaking he was aided by the powerful influence of Mott, Francis, Stevens, Griscom, and other celebrities, as well as by a number of the most respectable ladies of New York. If Sims had done nothing else, the energy and determination displayed in placing this institution in a proper working condition would be sufficient to entitle him to the gratitude of the public, and to establish his claims as a wise philanthropist. During his early connection with it, it afforded him an opportunity of introducing his peculiar operative procedures, and the profession and the public an opportunity of forming a true estimate of their value.

In 1861, Dr. Sims visited Europe, and during his sojourn in Paris was invited to perform his operations in the principal hospitals of that city, the great surgeons, men of world-wide renown, sitting as pupils at the feet of the American Gamaliel to be enlightened respecting a procedure which was completely to revolutionize the treatment of the surgical diseases of women.

The following year he took his family abroad with a view of educating his children; and availing himself of the reputation won during his first visit, he soon obtained a large and lucrative practice, patients flocking to him from all parts of the Continent, Great Britain, and even the United States. During his absence, extending into 1868, the French, Spanish, Portuguese, Italian, and Belgian governments vied with each other in investing him with their decorations. Napoleon III. made him a Knight of the Legion of Honor, and the Belgian Government conferred on him the order of Leopold I., while many of the most prominent medical societies enrolled him among their members. During the Franco-Prussian war Dr. Sims rendered important services at the head of the Anglo-American Ambulance Corps, for which he and his assistants received the thanks of the French Government.

At the meeting of the American Medical Association in Louisville in 1875, he was elected President of that body, and delivered his inaugural address the following year at the meeting of the Association in Philadelphia.

Dr. Sims has found time to contribute numerous articles to the periodical press, and to publish monographs on "Silver Sutures in Surgery," "Uterine Surgery," "Ovariotomy," "Intra-uterine Fibroid Tumors," "Trismus Nascentium," and "The Microscope in the Sterile Condition."

Of late years, owing chiefly to ill-health, his life was a nomadic one, most of his time being spent in Europe, where he was always sure of a warm welcome, greeted by crowds of wealthy patients, including not a few of the nobility. In 1880 he had a violent attack of pneumonia, from the effects of which he was very long in recovering.

Dr. Sims was one of the most generous and hospitable of men; with genial, winsome manners, with a mind of keen perceptions, well-stored with varied information. He was a fond and loving husband; a fond and loving father.

NEWS ITEMS.

YELLOW FEVER IN MEXICO AND ON THE BORDER.—The Consul at Guaymas, Mexico, in a letter to the State Department dated October 23d, says that the yellow fever is slowly diminishing at that place, only twenty-one deaths during the month to date, and but two new cases in past twenty-four hours. It is also abating at Hermosillo, only one death in the past twenty-four hours. He stated that the ports of La Paz and Mazatlan are now free from the scourge, and that clean bills of health are given to vessels clearing from those ports.

The Deputy Collector of Customs at Yuma, A. T., in a letter to Surgeon-General Hamilton, dated November 2d, says that, in his opinion, next season will be the dangerous one for that coast, as the germs of the disease were brought in by persons contracting it in Sonora and dying in Arizona. He also says that two distinct fevers coexisted in Sonora at the same time—the epidemic form being the specific yellow fever. He adds that the disease was very successfully treated by the use of an emetic composed of an infusion of the inner bark of the mesquit tree and a little common salt—"in each case the fever subsided rapidly and the patient was restored in a few hours."

Daily reports up to the 31st of October from Sanitary Inspectors W. F. Price, at Yuma, and W. E. Chesley, at Benson, A. T., show that no cases of yellow fever entered those places by rail, nor were there any arrivals from infected points in Mexico.

Assistant Surgeon Main reports, under date of Oct. 31, from Brownsville, Texas, the continued good health of that place and of Matamoras, Mexico. He says, however, that, owing to a tornado at Altala, in Mexico, the death-rate from yellow fever was greatly increased in that place, and gives the total number of deaths from the scourge to have been 1981, and in the adjacent villages not less than 3000. He adds that the above is no exaggeration, as the treatment of the sick was *nil.* In Mazatlan the mortality is given—deaths in the city, 1821; in its vicinity, 4000. At Acapulco, no definite account of the mortality could be obtained, but the fever was regarded as an endemic disease at first, and not until the death-rate became alarming were any sanitary measures inaugurated for arresting the disease. As this city is one of the principal sea-coast ports of the Pacific whose commerce is chiefly with the city of Mexico, a source of great danger to the interior may result from yellow fever epidemics at this place.

YELLOW FEVER AT HAVANA.—Sanitary Inspector D. M. Burgess, in a report to Surgeon-General Hamilton, dated November 1, says that there were five hundred and seventy-six deaths at Havana during the month of October, of these, eighty-six were from yellow fever, twelve of whom died in the Military Hospital, and the remainder (seventy-four) were private individuals or from merchant vessels. Dr. Burgess inspected the following named vessels bound to U. S. ports up to November 3: Span. bk. "Resuelta," for New Orleans, October 30—had one case of yellow fever on board while in port—was disinfected; Span. bg. "Victoria," for New Orleans, also had case of yellow fever on board while in port and was disinfected; Am. schr. "Christiana," for Key West, at a suspicious wharf; Am. str. "Hutchinson," for New Orleans, in open bay; Am. schr. "Sea Gull," for Key West, at a suspicious wharf; Am. str. "Santiago," for New York, in open bay; Am. str. "City of Washington," for New York, in open bay. Total number of deaths from yellow fever during the week, twenty.

REPORT ON THE CHOLERA IN EGYPT AND SYRIA.—The U. S. Consul at Beirout, Syria, in a communication to the State Department, dated September 20, 1883, furnishes the following report relative to the cholera in Egypt and Syria:

On the twenty-fourth of last June a case of cholera occurred in Damietta, a city of the Delta, the hygienic conditions of which were exceptionally bad, even for an Oriental city. The disease spread rapidly throughout this town, and during the few weeks of its duration swept away about one-fifteenth of the population. After the disease had prevailed for some time, a cordon was established around the city in which cholera had appeared. Notwithstanding this precaution, the dis-

ease spread to Cairo and the valley of the Nile above the capital.

While Alexandria was as yet free from cholera, a quarantine of ten days was established at Beirout against arrivals from Egypt. Arrivals were, however, permitted, and the Lazaretto, which has barely capacity for four hundred occupants, had at one time as many as fourteen hundred refugees. The Lazaretto of Beirout was established at a time when the city was small and enclosed within walls. It is a plateau projecting into the sea to the east of the old town and about a mile distant from it.

Being swept by the west wind, which blows from the old town, it was not especially liable to objection as a quarantine station against the plague, which was a disease rather contagious, and which could be measurably guarded against by household quarantine. But since the extension of Beirout, many houses have been built near it, and the abattoirs of the city are within a few hundred yards of it. It has therefore ceased to be a suitable station for a Lazaretto, being in effect a quarter of the city.

The arrangements of this Lazaretto are even worse than its situation. A few various buildings and a narrow camping ground are all the facilities for accommodating refugees.

The sanitary precautions were almost wholly neglected, and for a considerable time there was no resident physician. The different arrivals mingled with one another, with little attempt at isolation. I mean that passengers arriving at separate dates were able to mix with each other in the quarantine. As a specimen of the system adopted, there was a seller of iced drinks, who stood at the door of the Lazaretto, and sold his beverages to those inside and outside the walls. The cups were passed in, drained by the thirsty prisoners and then passed out again, to be used by the guards and outsiders, who thronged the outer rooms. On the third of August a soldier of the guard was taken with cholera, and at first sent in a public carriage to the military hospital in the town, but the doctor in charge declined to admit him. He was then taken to the hospital of the Sisters of Charity, where he was likewise refused admission. He was then taken back to the quarantine station, and died there. On the 5th of August, a girl, about a half a mile distant from the Lazaretto died of cholera. On the 7th of August, a woman in a remote quarter of the town was taken with cholera and died, and who it was said had washed the clothes of a man from the quarantine who did not have cholera.

Subsequently to these cases three deaths from cholera were reported by the quarantine officers. The last death occurred on the 14th of August. On the 10th of August an order from the Sublime Porte came for the establishment of a military cordon around Beirout. Against the cordon the American, British, German, Russian, Italian, and Spanish Consuls protested, telegraphing to their respective legations at Constantinople, as well as to the Governors-General of Syria and Lebanon, in identical messages, basing their protest on experiences during former epidemics, and the universal remonstrance of the medical men of Beirout, the municipal sanitary and foreign doctors, including American and French, that the cordon was useless, impossible, and dangerous. Previous to this time an order was issued for the discontinuance of the reception at Beirout of refugees from Egypt. In fact the cordon was inefficient, a number of persons passing through the cordon by paying a small fee. Such was the absurdity of the measure and its palpable deficiency, together with the actual suffering which it caused to the people by cutting off their supply of food and interrupting their business, while nevertheless the public health was exceptionally good, that after five days it was abandoned. On the 6th of September the last batch of refugees was discharged from the Lazaretto, and the city was declared free from cholera, and clean bills of health were given to vessels.

A review of this visitation opens up two inquiries: 1st. How did it happen that the first three deaths were persons not arriving from Egypt, and only one an inmate of the Lazaretto? 2d. Why did four deaths in the Lazaretto take place without any spread of the infection? Medical, as well as non medical, men are divided in opinion on the question. Some believe that the disease, both within and without the Lazaretto, was not Asiatic cholera, but sporadic *cholera morbus*. It is popularly believed that one of the cases outside was one of poisoning by a jealous husband. Certainly it is unparalleled that a crowded, ill-nourished, and ill-housed body of refugees in the Lazaretto should be exposed to the infection and escape with so small a percentage of seizures.

Two explanations may be given on the basis that the disease was genuine cholera: 1st. That its character was so far modified by unknown causes that it has largely lost its infectious properties. 2d. That the bivouac without shelter of so large a number of inmates was unfavorable to the development of cholera germs. Certainly the present epidemic in Egypt lacks the virulence and universality of former epidemics.

It is also worth while to mention that soon after the outbreak of the cholera in Egypt, a considerable number of sailing vessels began to come to the port of Beirout, where they were quarantined for fifteen to twenty days. The place of anchorage designated by the quarantine officials for the said vessels was very close to the town. From these vessels, I am creditably informed, the sailors were in the habit of slipping ashore during Ramadan at night and returning to their vessels before daylight.

The month of Ramadan commenced on the sixth of July, and ended August the fourth, during which the Moslems in the East, do not eat or drink anything from daydreak until sunset, but dissipate by eating and drinking during the night, which usually brings on much sickness.

Thus it seems a miracle that the cholera did not spread in Beirout. It is right, however, to give credit to the local authorities, who took every possible measure to render the sanitary condition of the town as good as it can ever be, by cleaning the streets most thoroughly, spreading large quantities of lime and other disinfecting matter, and watering all the public places twice a day, to cool the hot temperature of the locality. These sanitary precautions were, in the opinion of many, the principal reasons that the cholera did not spread in Beirout, granting that the above-mentioned cases were genuine cholera. Further, I may mention that soon after the cholera appeared in Egypt, about one half of the population of Beirout left the city and fled to Mount Lebanon, where the cholera has never spread during former epidemics, and where people feel perfectly safe from this dreadful disease.

REPORT OF SURGEON-GENERAL WALES. — In his annual report, Surgeon-General Wales, of the Navy, recommends that the medical departments of the great naval powers be invited to a conference, with a view to the adoption of a uniform nomenclature, classification, and tabulation of diseases, and of a system of interchange of periodical reports of the movement of disease from which international reports of sanitary conditions all over the world may be published at stated intervals.

The Surgeon-General advances the opinion that the present naval hospital system no longer fulfils the re-

quirements of modern sanitary science. He recommends that the establishments at Chelsea, Brooklyn, and Philadelphia be sold, and that station hospitals be built at convenient points for the accommodation of acute cases only. It is intended that chronic cases, and those likely to be of long continuance, are to be sent to a general hospital at a central point.

THE DARTMOUTH (N. H.) MEDICAL COLLEGE.—The largest class ever graduated from Dartmouth Medical College received their diplomas last Tuesday. The degree of M.D. was conferred upon forty graduates. A prize for the best examination in therapeutics was awarded to L. F. Wentworth, of Bridgewater, Mass.

LOUIS THUILLIER.—The plate commemorative of the services and death of LOUIS THUILLIER has been placed in the Normal School in Paris. It bears the following inscription, in letters of gold:

LOUIS THUILLIER
Mort pour la Science.
Alexandrie, 1883.

The remains of Thuillier will soon be removed to Paris, the expenses of the removal being borne by the French Government. The Municipal Council of Paris has decided that the name of Louis Thuillier shall be given to one of the streets of the Latin quarter.

MEDICAL WOMEN FOR INDIA.—A meeting was recently held in London for the purpose of considering the subject of medical women for India. Surgeon-General Hunter, M.D., F.R.C.P., presided. Mr. Kittredge, of Bombay, gave a detailed account of the efforts that had been made for the creation of a guarantee fund, by means of which competent female medical practitioners induced to visit India, might be assured a comfortable living. They had been enabled by the liberality of native gentlemen to secure already a guarantee fund amounting to between 40,000 and 50,000 rupees. Mr. Cama had given a donation of £12,000 for the erection of a hospital for women and children at Bombay. The Government had granted permission for women to dispense medicine; and, further, the authorities of the Calcutta University had conceded to females the right of training at the medical college and of qualifying for the degree of M.D. Apart from the great suffering which existed for want of medical women in India, this movement deserved support because of the impetus it would give to the moral and social improvement of native women.

CHICAGO MEAT.—For years the character of meat sold in the markets of Chicago has not been above suspicion. Chicago canned beef has also been the subject of a well-founded distrust on the part of consumers. This suspicion and distrust arose from the fact that animals known to be suffering with disease, such as hog cholera, cancer and splenic fever in cows, and foot-rot in sheep, were shipped to the stock-yards in this city, and slaughtered either by unscrupulous local dealers or by packers. There was great profit in the practice. This rascally trade is to be broken up. For some time the health department have had one inspector located at the stock-yards. Since September 1st, he has condemned and sent to rendering establishments, eighty-five head of cattle. At the present time, two inspectors are located there, and their inspection is severe. This inspection will undoubtedly be maintained, and there need be no further fear of the quality of meat offered for sale in Chicago. In connection with the inspection of cattle, it may be said that this inspection benefits other cities as well as Chicago. Inspector Lamb notified the Chicago health commissioners last month that three car-loads of cattle, containing twenty head affected with cancer, had been sent to a firm in Grand Rapids, Michigan. Notice of their approach was immediately sent to the health authorities there. It might be said, in passing, that Grand Rapids is not a good place in which to dispose of diseased meat, the health authorities being uncommonly watchful and successful in the prosecution of guilty parties.

In connection with the above, it is worthy of notice that the Commissioner of Agriculture, Mr. George B. Loring, has issued a very important circular, in which he has called, at Chicago, on November 15th and 16th, a conference of representatives of all bodies interested in the animal industries of the United States. At this convention it is proposed to discuss the subject of contagious diseases among our domestic animals, under the following heads: (1) The extent to which they prevail in this country; (2) the methods of their introduction and spread; (3) the methods by which they may be eradicated or isolated; (4) the efficiency of existing legislation.—*Sanitary News*, November 1, 1883.

TIN IN "TINNED" FOODS.—Tinned meats, soups, vegetables, and more especially fruits, are all, without exception, contaminated by metals; such is the irresistible conclusion of recent scientific investigation. In 1878, Mr. Albert E. Menke communicated to the *Chemical News* results of analyses of a tin of lobster, one of apples, and another of pineapple; the latter contained tin dissolved in the juice equal to 1.3 grain per pound, the lobster and apples a much smaller quantity. Mr. Hehner, in 1880, communicated to the *Analyst* the results of a prolonged and thorough investigation of the subject. He found tin in tinned French asparagus, American asparagus, peas, tomatoes, peaches, pineapples, white cherries, red cherries, marmalade, corned beef (five different brands), ox-cheek, ox-tongue (three kinds), collared head, tripe, oysters, sardines preserved in oil, salmon, lobsters, shrimps, curried fowl (two kinds), boiled rabbit, boiled mutton, roast chicken, roast turkey, soup, and in three brands of condensed milk. The amount of tin found does not appear large—*e. g.*, in the milk one-tenth of a grain per pound, in one of the soups half a grain per pound, and in a pound tin of preserved oysters seven-tenths of a grain per pound. On a later research, Mr. Wynter Blyth has found far larger quantities. In a recent report to the Vestry of St. Marylebone, detailing the examination of twenty-three samples of tinned apricots, tomatoes, pineapples, and cranberries, the amounts found calculated as stannous hydrate range from 1.9 grain to 14.3 grains per pound, the mean amount being 5.2 grains. The juice and fruit in some instances had a metallic taste. Several of the tins showed signs of corrosion.

The older school of toxicologists, as represented by Orfila, considered pure tin vessels innocuous; if accidents occurred, they were ascribed with confidence to the admixture of lead in the alloy, or to arsenic. The arsenic theory ceased to be held when it was found that arsenic was present in so small a quantity that an adult would have to spend more than forty years drinking and eating from tin vessels before he imbibed a poisonous dose; and even the explanation of lead so often accompanying the tin has not of late been considered sufficient, but the question is of some moment whether tin in itself, present in a soluble form contaminating food, may not act injuriously. All know the toxic action of the chloride of tin on the one hand, and the inactivity of stannic oxide on the other: it is evident that in tinned foods we have to do with neither, but with some form of stannous hydrate. The little

that is known of the action of stannous hydrate may be summed up in a few lines. Doses of about .174 gramme per kilogramme of body weight cause in guinea-pigs death with signs of intestinal irritation; but with doses smaller than .17 to .2 gramme the effects are uncertain, and the animals generally recover. Hence, supposing man to be affected in the same proportion, he would have to take from three to four drachms, or consume at a meal ten pounds of the most contaminated of Mr. Wynter Blyth's tinned fruits.

But it is not a question of immediate lethality, it is rather one for inquiry as to the action of small repeated doses continued for a long time. In the summer season, some families who go yachting, fishing, or travelling in remote parts often carry a considerable supply of "tinned" provisions, and must take, in the aggregate, physiologically active doses of stannous hydrate, possibly producing some slight dyspepsia or intestinal irritation. From time to time, indeed, serious symptoms are witnessed after eating tinned meats; but the exact cause of such illness has never been in any thorough way investigated. It must also be remembered that certain sugars now in the market contain tin in the proportion of about half a grain to the pound —no very great quantity in itself, but the small fractions of the metal found in this and that article of food in daily use may mount up until an active dose is taken. Physicians and medical men generally will do well to inquire closely into the diet of their patients suffering from obscure gastric affections; and it is hoped that, in the mean time, experiments may be made by competent men on the action of stannous hydrates.—*Med. Times and Gazette*, October 27, 1883.

TRACHEOCELE.—M. DÉTIS reports a case of tracheocele affecting a man æt. twenty-nine years, who, with the exception of an attack of rheumatism, had been in previous good health. After a severe attack of coughing, during an attack of bronchitis, he suddenly noticed a small tumor, about the size of a hazelnut, just above the sternum. Within three days' time it increased to the size of a pigeon's egg, and interfered with respiration and deglutition. It then remained stationary for three weeks, when it burst suddenly, discharging pus and blood, and then became reduced in size. After that it grew again slowly for a time, but was smaller and softer than before. It alternately grew larger and diminished with expiration and inspiration. Détis treated it by compression by a kind of truss, and after six weeks it was cured; but the patient became subject to chronic asthma, which required constantly increasing doses of morphia for its relief.

The reporter has been able to find records of twelve other cases, and from these and his own he draws the following conclusions: 1. Tracheocele may be caused by bodily exertion of any kind. 2. Its principal symptoms are enlargement, or expansion, during expiration, diappearance under compression, and an indistinct, muffled, and squeaky voice. 3. The prognosis is favorable. 4. The treatment is purely local, and consists in constant compression.—*Centralbl. f. Chirurgie*, July 7, 1883.

HEALTH IN MICHIGAN.—Reports to the State Board of Health, for the week ending November 3, 1883, indicate that inflammation of the bowels has considerably increased, and that measles, intermittent fever, and remittent fever have decreased in area of prevalence.

Compared with the average for the month of October in the preceding six years typho-malarial fever, remittent fever, and diphtheria were considerably less prevalent, and consumption, intermittent fever, diarrhœa, and whooping-cough were less prevalent in October, 1883.

Including reports by regular observers and others, diphtheria was reported present during the week ending November 3, and since, at twenty places; and scarlet fever at twenty-five places.

OBITUARY RECORD.—DR. E. H. TRUDEL, President of the Montreal School of Medicine and Surgery, and Professor of Obstetrics, died on the 5th inst., aged 63. He had practised in Montreal since 1844, and for many years had been one of the most prominent physicians of the Province.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM NOVEMBER 5 TO NOVEMBER 12, 1883.

BACHE, DALLAS, *Major and Surgeon.*—Par. 1, S. O. 238, A. G.O., October 18, 1883, assigning him to duty at Willet's Point, New York, revoked.—*Par. 2, S. O. 252, A. G. O.*, November 3, 1883.

STERNBERG, GEORGE M., *Major and Surgeon.*—Leave of absence granted October 4, 1883, extended one month.—*Par. 4, S.O. 255, A. G. O.*, November 7, 1883.

VICKERY, R. S., *Major and Surgeon.*—Assigned to duty at Fort Townsend, W. T.—*Par. 3, S. O. 149, Department of the Columbia*, October 29, 1883.

WOLVERTON, WILLIAM D., *Major and Surgeon.*—Granted leave of absence for one month.—*Par. 6, S. O. 201, Department of the East*, October 24, 1883.

MERRILL, J. C., *Captain and Assistant Surgeon.*—Granted leave of absence for one month.—*Par. 7. S. O. 201, Department of the East*, October 24, 1883.

PATZKI, J. H., *Captain and Assistant Surgeon.*—Granted leave of absence for three months, on Surgeon's certificate of disability. —*Par. 6, S. O. 254, A. G. O.*, November 6, 1883.

OWEN, W. O., *First Lieutenant and Assistant Surgeon.*—Relieved from duty at Vancouver Barracks, W. T., and assigned to duty at Fort Stevens, Oregon.—*Par. 2, S. O. 148, Department of the Columbia*, October 26, 1883.

WILSON, GEORGE F., *First Lieutenant and Assistant Surgeon.* —Assigned to temporary duty at Fort Townsend, W. T.—*Par. 2, S. O. 149, Department of Columbia*, October 29, 1883.

OFFICIAL.

WAR DEPARTMENT, SURGEON-GENERAL'S OFFICE, WASHINGTON, D. C., October 24, 1883.

SURGEON-GENERAL CHARLES HENRY CRANE.

WITH profound sorrow, the death of BRIGADIER-GENERAL CHARLES HENRY CRANE, SURGEON-GENERAL, U. S. A., which occurred at his residence in Washington, D. C., October 10, 1883, is announced to the officers of the Medical Department of the Army.

General Crane, son of the late Colonel I. B. Crane, 1st. U. S. Artillery, was born at Newport, R. I., July 19, 1825, and received his early education at Maple Grove Academy, Middletown, Conn. He entered Yale College in 1840, graduating in 1844, with the degree of Bachelor of Arts. The degree of Master of Arts was conferred upon him by the same Institution in 1847.

He graduated in medicine at the Medical Department of Harvard University in August, 1847.

Having been approved by an Army Medical Examining Board, December 11, 1847, as a candidate for the position of Assistant Surgeon, U. S. Army, he was immediately placed under contract as an Acting Assistant Surgeon, and accompanied a detachment of troops to Mexico, arriving at "Camp Washington," near Vera Cruz, February 20, 1848. He was commissioned Assistant Surgeon, U. S. Army, February 14, 1848. From February 20, to July, 1848, he served with the "Army of Invasion" in Mexico.

On returning from Mexico, early in August, 1848, he reported for duty at Fort Columbus, New York Harbor,

and was assigned to duty with the 2d U. S. Artillery. October 8, 1848, he accompanied two companies of the 2d U. S. Artillery to Fort Monroe, Va. He was then ordered to Florida with troops, arriving at Fort Pickens, Pensacola, Fla., November 16, 1848. From this date until August 10, 1851, he served at Key West Barracks, St. Joseph's Island, Forts Pickens, Brooke, Fraser, Casey, and Myers, and with expeditionary forces in the field. On being relieved from duty in Florida, and at the termination of a leave of absence, he reported for duty December 18, 1851, and on January 13, 1852, sailed from New York in the steamer "Falcon," with recruits for California. He arrived at Benicia, Cal., February 28, 1852, and was assigned to temporary duty at Benicia Barracks. From June 16, until September 1, 1852, he was engaged in field service against hostile Indians near Merced River, Cal. From September 23, until November 10, 1852, he was again in the field with an expedition in the Sacramento Valley, Cal. November 10, 1852, he arrived at Fort Jones, Cal., where he remained on duty until July 15, 1853.

From October 31, 1853, until March, 1856, he was on duty at Fort Lane, Oregon. During these years he was actively engaged in Post duty and with military expeditions against Indians, prominent among which was that against the Rogue River Indians in 1856, where he rendered distinguished service.

On August 7, 1856, he was ordered to Fort Yamhill, Oregon, where he served until relieved from duty on the Pacific Coast in December, 1856.

Reporting for duty in New York, he served for a short time with the Medical Purveyor, U. S. Army. From May 1, 1857, until September 20, 1859, he was one of the members of an Army Medical Examining Board convened to meet in New York City. Being relieved from this duty, he remained in New York, acting at times as Medical Purveyor.

September 20, 1859, General Crane accompanied Lieutenant General Scott to San Juan Island, on his diplomatic visit, returning to New York December 12, 1859, and continuing on duty as Attending Surgeon at Headquarters of the Army, and on special duty until February 28, 1862.

He was promoted Major and Surgeon May 21, 1861.

On February 28, 1862, he was assigned to duty as Medical Director, Department of Key West, Fla. On June 30, 1862, he was transferred to Hilton Head, S. C., and assigned to duty as Medical Director, Department of the South. July 31 to August, 1863, he is reported as awaiting orders at Washington, D. C., and on duty connected with Prisoners of War.

September, 1863, he was placed on duty in the Surgeon-General's Office, Washington, D. C. July 28, 1866, he was appointed Assistant Surgeon-General, U. S. Army, with the rank of Colonel, and upon the retirement of General Barnes, was appointed Surgeon-General, July 3, 1882.

March 13, 1865, General Crane received the brevets of Lieutenant Colonel, Colonel, and Brigadier-General, for faithful and meritorious services during the War of the Rebellion.

In the death of Surgeon-General Crane the Medical Department of the Army sustains a serious loss. Still in the vigor of life, and with a resonable prospect of several years of active service in the position to which he had been but recently promoted, it has pleased an inscrutable wisdom to remove him from our midst.

His record, honorable and spotless, lives after him; a source of pride and satisfaction to his friends, a model worthy of imitation by all.

The larger portion of his official life was engaged in administrative duty, for which he had always manifested a peculiar fitness.

Selected to assist in the arduous and important duties devolving upon this Office during the latter years of the War of the Rebellion, his sound judgment, delicate sense of justice and right, deliberate action, and firm decision, soon won for him an enviable reputation, and materially assisted in raising the Medical Corps of the Army to the high degree of discipline and efficiency which has characterized it in the past and present.

In the literary and scientific work of the office he manifested untiring interest; to his watchful care, encouragement and aid, are largely due the successful progress and completion of undertakings which have gained for the Medical Corps the admiring recognition of the world.

Thoroughly acquainted by early experience with the requirements of his Department, assiduously attentive to the routine of business, even in its details, punctilious in regard to the rights of all, and earnest in his endeavors to promote harmony and a healthy *esprit du corps*, General Crane labored patiently, faithfully, and effectively for the best interest of his charge.

In his private life he was conspicuous for his firm, devoted friendships; for his kindly interest in, and sympathy with, the joys and griefs of those about him; for his habitual attention to the courtesies which adorn life. Unselfish and generous to a fault, his many deeds of kindness and charity were done quietly and without ostentation.

He needs no higher tribute to his worth as a man than the widespread sorrow which his loss has occasioned, and the respect for his memory which will long be cherished by all who knew him.

General Crane, at the time of his death, was one of the Commissioners of the Soldier's Home, a Visitor to the Government Hospital for the Insane, and to the Columbia Hospital for Women.

After appropriate funeral services at his late residence in this city on October 11, 1883, his remains were removed to Shelter Island, N. Y., for interment.

D. L. HUNTINGTON,
Acting Surgeon-General, U. S. Army.

NOTES AND QUERIES.

COLLEGE DIPLOMAS.

To the Editor of THE MEDICAL NEWS.

SIR: I would like a brief space in your journal to state a few facts in reply to an article (THE MEDICAL NEWS, Sept. 22, 1883) referring to one of the graduates of the Medico-Chirurgical College, thereby reflecting on said College. Rev. R. V. Danne, on applying for the senior course, presented two authenticated certificates from the University of Melbourne, Australia, testifying to his having attended two full courses in medicine at that institution, also a certificate to that effect from Mr Spencer, American Consul in Australia. Under no other circumstances could he or any one be admitted to the senior class in the Medico-Chirurgical College, which maintains a three years' course. Mr. Danne passed a satisfactory examination and received his diploma. If the faculty were deceived, it was in the face of apparently most "conclusive evidence." As the article further states, our standard *is* high, and it is our intention to adhere to our announced principles, and in every detail to labor for the elevation of the medical profession.

Very respectfully,
WM. S. STEWART, M. D.,
Dean.

MEDICO-CHIRURGICAL COLLEGE, PHILADELPHIA,
Nov. 14, 1883.

THE MEDICAL NEWS *will be pleased to receive early intelligence of local events of general medical interest, or of matters which it is desirable to bring to the notice of the profession.*

Local papers containing reports or news items should be marked.

Letters, whether written for publication or private information, must be authenticated by the names and addresses of their writers—of course not necessarily for publication.

All communications relating to the editorial department of the NEWS *should be addressed to No. 1004 Walnut Street, Philadelphia.*